Comprehensive Planning Committee

Meeting Agenda

Thursday, June 18, 2020

2:00 PM

Office of HIV Planning 340 N. 12th Street Suite 320
Philadelphia, PA

- **Call to Order**
- **Welcome and Introductions**
- **Approval of Agenda**
- **Approval of Minutes *(February 20th, 2020)***
- **Report of Staff**
- **Report of Chair**
- **Public Comment**
- **Discussion Items**
  - **Ending the HIV Epidemic (EHE) Update**
  - **Recommendations for Allocations Process**
- **Old Business**
- **New Business**
- **Announcements**
- **Adjournment**

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

The next Comprehensive Planning Committee meeting scheduled is **TBD**

Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, February 20, 2020
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Sarah Nash, Allison Byrd, Keith Carter, Mark Coleman, David Gana, Pamela Gorman, Gerry Keys

Absent: Katelyn Baron, Sade Benton, Evette Colon-Street, Janice Horan, Peter Houle, Kenya Moussa, Jeanette Murdock, Erica Rand, Joseph Roderick, Gail Thomas (Co-Chair)

Excused: Gus Grannan (Co-Chair), Marilyn Martinez

Guests: Blake Rowley, Renee Cirillo, Jessica Browne (AACO), Javontae Williams (AACO)

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

Call to Order/Introductions: G. Keys offered to chair the meeting in the absence of the co-chairs. G. Keys called the meeting to order at 2:15 PM.

Approval of Agenda: G. Keys presented the agenda for approval. **Motion**: K. Carter motioned, D. Gana seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes: (*January 16, 2020*) G. Keys presented the previous meeting's minutes for approval. **Motion**: K. Carter motioned, P. Gorman seconded to approve the January 16, 2020 meeting minutes. **Motion passed**: All in favor.

Report of Staff:

M. Ross-Russell reported on the Positive Committee's 20th Anniversary. The process involved contacting and interviewing past and present Positive Committee members who wanted to discuss their involvement with the committee. She noted that there were flyers in the conference room. The first flyer was for providers to post in their offices with N. Johns's contact information. The second flyer was created by a Positive Committee member and had available interview dates for past and present members seeking involvement.

M. Ross-Russell also reported that the March HIPC evening meeting was going to be an EHE (Ending the HIV Epidemic) Town Hall event hosted by AACO. AACO wanted to ensure significant community involvement to get as much feedback for the EHE plan as possible. She reported that the event was still taking place at OHP's location. The OHP conference room could hold around 80 people, and RSVP was mandatory.

M. Ross-Russell reported that OHP had hard copies of the EHE draft plan, but the office was asking for participants to return the hard copies after the meeting.

G. Keys asked if the 20th Anniversary Project for the Positive Committee would also be a tribute to members that had passed away. M. Ross-Russell responded that including individuals who passed away would be complicated since they needed permission to use their names and photos. Thus, OHP would need to contact family members. G. Keys suggested paying tribute to members without mentioning names.

Report of Chair:

None.

Discussion Items:

—Ending the HIV Epidemic (EHE)—

J. Williams reported he had talked with PrEP providers at an AACO quarterly meeting. He noted that there were challenges with prevention that also existed regarding treatment. He asked that the committee keep the overlapping challenges/barriers in mind when reviewing the EHE pillars.

J. Williams noted that the current EHE draft was not the finalized plan and AACO needed more feedback before finalization. AACO was asking that the committee and council bring guests to the OHP sponsored EHE meeting. He reminded the committee that they would not focus on implementation of the plan today. Instead, AACO wanted feedback about populations and other "big picture" items. Small edits such as rephrasing were also welcomed.

J. Williams asked everyone to turn to page 21. D. Gana read the goal of Pillar 2: Treat: Over the 5-year period, 91% of PLWH with evidence of care in the last 5 years will reach viral suppression. J. Williams explained that the 5-year period began once Philadelphia received the EHE money as soon as March 1st, 2020. The amount could be anywhere from $700,000 to $9 million in funds. "Evidence of care in the last 5 years" was a noteworthy aspect of the goal since there were around 5,000 individuals with no evidence of care within the last five years. These people may be deceased or have left Philadelphia and should not be counted.

M. Ross-Russell added that the start of the grant year and the actual administration of funds were separate. Implementation of the plan would start March 1st regardless of whether the money was received after the start date.

P. Gorman read Strategy 1: Improve access to rapid HIV medications and medical appointments. She also read the corresponding activities for strategy 1. Please refer to page 21 for a full read of the activities. M. Ross-Russell asked if the strategy for increased access to immediate ART would be in accordance with federal treatment guidelines.

P. Gorman noted that there is a difference between writing a prescription and actual initiation of ART. J. Williams explained that the strategy is mainly about increasing access to and guidance

for immediate ART protocol. They must do as much as possible on the provider side since they cannot ensure specific protocol for each individual patient. P. Gorman suggested that the plan clarifies ART and explains whether it begins with writing the prescription or with the patient taking the medication. J. Browne agreed, adding that there could be a portion involving MCM to ensure the patient begins medications.

P. Gorman asked for more clarification on "access" to medications—does this mean ability to get prescriptions filled or actual access to the medication? J. Browne said AACO was connecting with providers to further ensure that the physical medications are readily available. M. Coleman asked if MAT centers could also distribute HIV medications. S. Arrighy responded that there are MAT centers in NJ that do HIV testing and medication. However, they recently discovered an issue wherein some clients were selling their prescriptions.

S. Nash said that the goal of the strategy is to reach viral suppression, but the reason people are unable is because they do not have consistent access to care. She said that the second bullet speaks to diagnosing HIV, and that may fit in a different pillar since it does not directly fit into viral suppression and care. M. Ross-Russell suggested there needed to be more context within the plan to elaborate on and justify pieces of the plan. She explained that there is a large gap from when people are tested and then linked to care. This was the specific gap that this goal—and specifically the second bullet within the first strategy—was trying to achieve. Providing medication immediately after testing would help to close the gap in care. She also said that there are many providers that are talking about expanding, and there has been discussion around the fact that these places need to have multiple sites in multiple locations around the city in order to make a difference.

P. Gorman said Medication-Assisted Treatment programs in the second bullet of Strategy 1 should be changed to Substance Use Treatment programs for more clarity. K. Carter asked about the refills for MAT. S. Arrighy said that they give a 30-day supply and then come back. K. Carter asked why people coming in for MAT cannot also receive their HIV medication in conjunction. G. Keys explained that it depends on the agency and what they can support or have access to.

B. Rowley read Strategy 2: Improve the capacity of the HIV medical system to retain patients in care. J. Williams noted that this strategy was mostly about retention. G. Keys read the first activity. J. Browne said that the Data to Care Program works with surveillance unit at AACO to find patients out of care and connect with them to get more information, follow up with them, interview on barriers the patient experienced, and link them back to care. B. Rowley read the second activity of Strategy 2. J. Williams explained that this activity is about meeting the needs of a provider's patient population; for example, if there is a high Spanish-speaking population a provider is serving, there needs to be an appropriate amount of Spanish-speaking staff.

R. Cirillo read the first bullet under the second activity of Strategy 2: "PDPH will identify…….improve patient retention." J. Williams explained that this bullet is about relinking people to where they last received care. D. Gana read the second bullet under the second activity: "PDPH will suggest…retention including." J. Williams explained that the recipient noted that the consumer service and satisfaction surveys have informed all of the following bullet points under

the one D. Gana previously read. D. Gana read the rest of the bullet points under "PDPH will suggest...retention including."

B. Rowley asked how PDPH was going to help places that were experiencing a model overhaul and couldn't handle the massive change. J. Williams explained that those higher up must get on board. Data backs and protects decisions that are being made to change the models. They must work from the top down to ensure those at the top understand why change must occur. He said giving menus of interventions would be helpful, and even if there are institutional barriers, they need to find other ways around it. For example, providers can still achieve goals with minor tweaks to the plans. Ultimately, the plan is about following the standards of care.

S. Arrighy said that at her company, they change their hours every so often to accommodate individuals who cannot make regular hours. K. Carter commented on how some providers may have evening hours but patients still do not show up. He asked if this was because of lack of advertising, agency management, or other issues. J. Williams responded that such an issue may be agency-specific, though fixing the issue may take a change in culture.

M. Ross-Russell said that on the OHP website there is a resource inventory. M. Ross-Russell said that when crafting the OHP resource inventory, it became apparent that many providers did not post their hours. Patients do not know when to call organizations and depend heavily on outdated websites. Many individuals will not call providers if there are no hours listed on their websites. P. Gorman said it is a federal requirement to post hours, so these providers could be fined.

G. Keys added that many agencies may look good on paper but purposefully do not advertise because it would be too costly. Providers do not want to be financially overburdened, so they may not advertise even though they "offer" a service or certain hours.

J. Williams said that a challenge with providers is acknowledging medical professionals have weird schedules and hours. Medical professionals also need to be accommodated and HIV care needs to "work with" strange schedules. J. Browne added that aggregate Date to Care data showed inability to schedule an appointment because of no evening or weekend hours was the #1 barrier to care. This barrier was so significant that it was double the second barrier.

B. Rowley mentioned that if there is contractual obligation for listing hours and services where clients can see them, this should be mentioned within the EHE plan.

B. Rowley read Strategy 3: Address the social determinants of health to improve healthcare outcomes among PLWH in Philadelphia through behavioral health care, housing, and supportive services. J. Williams asked for feedback on the strategy for more concise wording, explained that they were not intending to address *all* social determinants of health. M. Ross-Russell suggested taking out "social determinants" and changing it to "health disparities."

K. Carter read the Behavioral Health Care bullets under Strategy 3. B. Rowley asked if these bullets were about creating medical homes for clients. J. Williams said it was about trying to move the HIV standard of care in that direction, yes.

P. Gorman mentioned that there is an initiative to integrate behavioral health into primary care settings. She asked why this bullet was not included? She explained that getting individuals from a medical care setting who scored high on behavioral health tests to behavioral health care would involve integrating the two. G. Keys said integrating behavioral health counselors is a good idea, but the issue is that counselors are often not representative of the community. They are often young, white, and from the suburbs. There is a big turnover because they constantly leave. The main issue is finding behavioral health staff that identify with the people they are working with. M. Ross-Russell noted that the Philadelphia and surrounding areas are medical provider shortage areas. There are not a sufficient amount of providers, so individuals from the suburbs often come to the city for work.

M. Coleman read the Housing activity. K. Carter noted that the difference between NYC and Philadelphia is that NYC has a budget where those diagnosed with HIV can receive housing. M. Ross-Russell added that NYC has $115 million in RWHAP and Philadelphia $12-13 million. She added that the group also needs to consider that RWHAP only pays for short term housing. K. Carter said that mayor's office/Office of Homelessness Prevention and engaging industry should be added to key partners.

M. Ross-Russell said that there are businesses and housing complexes that have participated in housing PLWH. They may want to consider leveraging these businesses to find a different approach. J. Williams said that when they design housing services, they must recognize that people may feel stigmatized and therefore do not want to be in a housing service that is overtly for PLWH.

G. Keys, M. Coleman, B. Rowley, and D. Gana read the Supportive Services bullets under Strategy 3. B. Rowley asked how they can include job readiness or some sort of supportive job services within these bullets. He explained that particularly transgender communities receiving EFA often find themselves in a cyclical, financial space. There needs to be more supportive services that can help people break the cycle.

M. Ross-Russell said that the ability to pay for educational programs after the fact would be important and added that EHE does not have the same restrictions as RWHAP. EHE would be able to support such educational programs such as job readiness. J. Williams said there is some room for training within agencies, and they may be able to look for agencies to sustain educational programs. The Health Department does not have to work on managing every program, and programs such as 340B programs can sustain important initiatives that would ultimately help EHE.

P. Gorman noted that partnering with external resources is missing—they need to identify seed money or agencies that can work with or fund others to provide solutions. S. Arrighy added that the counties may have "disputes" and need to combine powers and help each other out for the better. J. Williams said there is a lot of history of collaboration, but there still needs to be a rebuilding of trust and mending of personal and agency relationships. J. Williams added that when the plan is in Phase 3 (outside of Philadelphia), they will be moving to enhance collaboration within the counties.

K. Carter read Strategy 4: Increase knowledge, close information gaps, and empower people living with HIV to improve their health. J. Williams explained that this strategy is all about empowering people to take care of their own health. K. Carter read the corresponding activities. J. Williams explained that the rights-based portion was about protecting people's HIV status. This also ensures that clients have the knowledge that helps them protect their own health and maintain privacy.

P. Gorman said that the second bullet of Strategy 4 could be expanded to highlight which targeted technical assistance activities are being referenced. She also asked if targeted technical assistance included sensitivity training. J. Williams responded that agencies differ in what they need and can use the Health Department for consultancy. P. Gorman said that the statement for the second bullet is vague and many may think it is patient-based (nutritional training for patients, for example) and less staff-based (such as training for scheduling).

J. Williams said that he would prefer that there is a situational analysis and EPI-data foldout that would allow people to know the data that is informing the bullets. He explained that this would provide more clarity. M. Ross-Russell asked about the distribute rights-based, medical consumer education tool kits for PLWH portion of the plan. She said that there is an education component with providers and clients that lets the clients know their rights and the provider's rights. She asked if this part of the plan was emphasizing that educational portion and what is expected from the provider. J. Williams said that it references that but also adds onto it, letting people know about their rights with a particular provider and their healthcare in general. They want to make sure clients know about what their treatment entails and provide a more comprehensive education project.

R. Cirillo asked about individual medical facilities regarding the data dashboard. She considered that it may be misleading when detailing how well a service is provided. J. Williams said that there can be institutional issues occurring that may affect data. Therefore, they would need context to accompany the data. However, there needed to be a way to hold providers accountable. He said there would be specific key indicators that could help to analyze and contextualize data. He said this would be EMA-Wide though the implementation is not completely fleshed out.

P. Gorman clarified that this information would be shared with the public, and J. Williams affirmed this. J. Browne said that the Information Systems Unit would be involved with making decisions about the dashboard. Regarding roles and responsibilities, K. Carter asked if those were updated yearly for the patients to know what's new. J. Williams said he would look into that.

G. Keys asked everyone to hand in their sheets if they wrote anything for feedback.

Old Business:

None.

New Business:

M. Ross-Russell said that the Prevention Committee and Comprehensive Planning Committee could have a combined committee meeting to have an EHE Workgroup discussion. The two subcommittees would likely switch off hosting the meetings monthly. Once they know the first subcommittee hosting the meeting, OHP would disseminate that information to HIPC.

Review/Next Steps:

G. Keys said they would continue their EHE discussion.

Announcements:

None.

Adjournment:

G. Keys called for a motion to adjourn. **Motion**: P. Gorman motioned, K. Carter seconded to adjourn the February 2020 Comprehensive Planning Committee meeting. **Motion passed**: All in favor.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- February 2020 Comprehensive Planning Meeting Agenda
- January 2020 Comprehensive Planning Meeting Minutes
- February 2020 EHE (Pillar 2) Feedback Worksheet