Meeting Agenda

VIRTUAL:
Thursday, February 11, 2021
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
    - Greetings to New Members & First-Time Attendees
- Approval of Agenda
- Approval of Minutes *(January 14, 2020)*
- Report of Co-Chairs
- Report of Staff
    - Roles and Responsibilities
- Presentation
    - CSU & ISU Presentation —*Evelyn Torres*—
    - Review of Service Categories—*Ameenah McCann-Woods*—
- Action Items
    - Recruitment Ad-Hoc Workgroup
- 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*
    - Retention & Recruitment LC – *Keith Carter*
- Old Business
- New Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next HIPC meeting is
VIRTUAL: March 11, 2021 from **2:00 – 3:30 p.m.**
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

HIV Integrated Planning Council

VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, January 14, 2021
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Daniel Angelis, Susan Arrighy, Juan Baez, Mike Cappuccilli, Keith Carter, Mark Coleman, Lupe Diaz (Co-Chair), Alan Edelstein, Pamela Gorman, Gus Grannan, Sharee Heaven (Co-Chair), Gerry Keys, Kailah King-Collins, Marilyn Martinez, Lorett Matus, Erica Rand, Sam Romero, Clint Steib, Evan Thornburg (Co-Chair)

Guests: Elise Borgese, Ebony Boswell, Kathleen Brady (AACO), Chris Chu (AACO), Debra D'Alessandro, Tira Faison, Meghan Gannon, Ameenah McCann-Woods (AACO), Blake Rowley, Desiree Surplus, Nicole Swinson, Adam Williams

Excused: Dave Gana, Allison Byrd, Nhakia Outland

Staff: Beth Celeste, Debbie Law, Nicole Johns, Mari Ross-Russell, Sofia Moletteri, Julia Henrikson

Call to Order: L. Diaz called the meeting to order at 2:04 p.m.

Introductions: L. Diaz and S. Heaven introduced themselves. M. Ross-Russell explained that C. Terrell, the former Governmental Co-Chair, as appointed by the mayor, has now stepped down because of a conflict in his schedule with the HIPC meeting. She introduced the new governmental co-chair, E. Thornburg as the Health Equity Advisor for AACO. E. Thornburg introduced herself and explained that she took the position as Health Equity Special Advisor in August to assist with EHE, overseeing and implementing health equity design internally and for providers. She previously worked in the Mayor's Office of Diversity, Equity and Inclusion as the Director of Training and Program Development. She was also the Deputy of the Mayor's Office of LGBTQ+ Affairs. She had a history of working with marginalized populations such as youth, elders, LGBTQ+ identified individuals. She had experience in HIV advocacy with MANNA and the AIDS Law Project. She said that anyone could contact her via email with any questions.

L. Diaz welcomed attendees who applied for the HIPC and were waiting for the mayor's office to appoint them. If anyone had any questions, she asked that they type them in the chat box. She asked everyone to introduce themselves in the chat box.

Approval of Agenda:
L. Diaz referred to the January 2021 HIPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, C. Steib seconded to approve the January 2020 Planning Council agenda. **Motion passed:** 82% in favor 16% abstaining.

Approval of Minutes (*December 11, 2020*)
L. Diaz referred to the December 2020 HIPC minutes S. Moletteri distributed via email. L. Diaz asked for a motion to approve the December 2020 minutes. S. Romero amended the minutes, noting that he was in attendance. **Motion:** K. Carter motioned, C. Steib seconded to approve the amended December meeting minutes via a Zoom poll. **Motion passed:** 81% in favor, 16% abstaining.

Report of Co-Chairs:
L. Diaz explained that she sat with the LGBT Youth Equity Council, and she heard that HIV+ individuals were phase two for the COVID-19 vaccine. Other people with immunodeficiency issues had also become part of phase two. The LGBT Youth Equity Council, she explained, were having people write to PDPH to let them know that those with immunodeficiencies, including HIV, need to be higher on the list. Those interested in participating could contact L. Diaz.

Report of Staff:

N. Johns said that since interpersonal connection was more difficult in virtual environments, they were to try a new activity. She pulled up the interactive Q&A forum, Slido. She asked everyone to answer the following questions:

First Question: "Why are you a HIPC member/Why are you attending as a guest?"

Second question: "What did HIPC/OHP do well and need to improve upon in 2020?"

Third question: "What can HIPC/OHP improve in 2020?"

N. Johns asked that everyone let her know if they liked this activity and would like to do it again.

Regarding recruitment, M. Ross-Russell said that OHP and the Nominations Committee had voiced concerns specifically related to recruitment. In order to bolster recruitment efforts, OHP has looked into the hivphilly.org webpage. She noted that after the virtual allocations process, it became apparent that participants appreciated the access to materials on the website. OHP separated out information around HIPC and OHP. There was a new "About HIPC" page that outlined why HIPC existed, the requirements, etc. The page also linked to the Planning Council Primer for more in-depth information. The page also mentioned demographics and the demographic composition of HIPC versus HRSA's demographic requirements.

Since there were so many questions about the tax clearance process, M. Ross-Russell explained that there was now clarification around this on the website. It specifically noted that the Chief Elected Official of the grant is the mayor, and the mayor required the tax clearance because it is city law for all committee appointments.

M. Ross-Russell added that OHP also added a "Member Resources" page which linked to Bylaws, Robert's Rules, Acronyms, Policies, etc. They also included two plans: The EHE plan which would be used as a roadmap for the upcoming Integrated Plan, and the older Integrated Plan from before EHE. OHP was also looking into how to increase community participation to

help with a recruitment plan. One idea was to look at existing trainings—such as the LEAP training in Houston—and to modify them for the Philadelphia EMA. Then they can look to recruit through government, providers, QM program, etc. Another option for recruitment was the creation of an ad-hoc workgroup. The goal was to have individuals knowledgeable and participating before the allocations process.

Public Comment:
None.

Action Item:

—Continuing Resolution—

A. Edelstein introduced himself as the Finance Committee co-chair. He said he would now be presenting the preliminary FY 2021 EMA budget for approval by HIPC with the spreadsheets presented on the screen.

A. Edelstein explained, the City of Philadelphia was notified of a Continuing Resolution for the budget, the EMA received a partial award. What they need to do, now, as a Planning Council was adopt a spending plan using the draft budgets. In doing so, they needed to review their spending plans made in August 2020 from the allocations process. What M. Ross-Russell had prepared, he explained, were spreadsheets that reflected the spending plans from August. He also noted that the plans reflected the most recent numbers for changes in the distribution of the HIV epidemic share within the three regions.

A. Edelstein referred to the first spreadsheet for Philadelphia County. He explained that above the line were Ryan White core service categories, which the federal government had determined as the most important services for PLWH, and below the line were the supportive services. A. Edelstein pointed to the percentage of the grant award allocated to each service category below the column, "Percentages Based on FY2020/2021." Here, you could see that 86.48% of funds allocated were going to core services. He noted that the mandated minimum for core services was 75%. Moving across columns, he explained that the second column was the level funding for FY 2020/2021 year ending in February 2021, and the third column (blue font), reflected the level funding budget for FY 2021/2022 beginning March 2021. In the blue column, highlighted the percentage "71.050%" which he explained as Philadelphia's share of the HIV epidemic from most recently available 2018 statistics. The fourth column, he explained, were the percentages each service category held within the full Philadelphia County grant based on the blue column to the left.

A. Edelstein explained that he was going to ask the Council to adopt the blue column which was reflective of allocation decisions made in August, with the new data on share of the HIV epidemic.

A. Edelstein then looked at the PA Counties and NJ Counties spreadsheets. For NJ, he said that the share of cases increased, so the level funding scenario increased, and the NJ Counties

received an extra $69,578. The other two counties had decreases in their share of the epidemic, so their funding decreased slightly.

A. Edelstein brought up the FY2021 Allocations Decisions and Directives Worksheets. He said this sheet reflected the narrative behind each funding decision made in the summer. He read through the level funding budget scenarios for the three regions. For New Jersey, $69,578 from NJ Counties New Level Funding Budget is to be moved into EFA-Housing and all other funded service categories are to stay at the previous Level Funding Budget. For Pennsylvania, all funded service categories are to be proportionally decreased based on the New Level Funding Budget which includes the decrease of $47,589. Philadelphia, 30% or $96,471 is to be taken from EFA-Pharma to offset the $21,990 decrease from the New Level Funding Budget, the remaining $74,481 is to be added to EFA-Housing and the remaining categories stay the same.

A. Edelstein underscored that they would be voting on approval of partial award based on continuing resolution. When the final award arrives, they would need to review the budgets and vote once again.

M. Ross-Russell clarified that continuing resolution meant that the federal government had not yet approved the budget this year, so to continue spending and funding services, they would need to vote on a partial award. In the past, the Planning Council created a policy for this scenario to vote so that money would continue to flow to providers and services. The continuing resolution, she explained, was a stop-gap measure. They would not know what the final award was until the federal government approved the budget. Core Services, she reminded, were considered medical services, and the support services were those that helped support a medical model.

N. Swinson asked if it was possible to get a copy of the charts to refer back to after the meeting. During the in-person process, A. Edelstein said, all spreadsheets were passed out to attendees. However, the charts also existed as PDF files. N. Johns said she would include the PDF file of the spreadsheets in the chat. A. Edelstein said that it may be an oversight that the spreadsheets were not included in the packet. M. Ross-Russell reminded everyone that when looking at the spreadsheets, the spreadsheets were just so the recipient could continue to provide funding for services but were not representative of the final award. Once they received the final award, they would vote to approve a budget based on whether it was closer to level, 5% increase, or 5% decrease.

A. Edelstein asked that the funding decisions for the different scenarios be sent out to everyone via email along with the spreadsheets. M. Ross-Russell added that the funding scenarios were already available on the website from the August 6th meeting packet as well. K. Carter reminded everyone that the budget scenarios were for the upcoming funding year.

A. Edelstein reiterated that they would be voting on the spending plan for partial grant award resulting from a continuing resolution. They would vote to approve the budget as represented in the blue column which reflected the level funding spending plans made in August by HIPC.

Motion: A. Edelstein called for a motion to approve the level funding budget on a continuing resolution based on the level funding decisions made in August as recommended by the Finance Committee.

Vote:

D. Angelis: in favor
K. Carter: in favor
E. Rand: in favor
L. Matus: in favor
C. Steib: in favor
E. Thornburg: abstaining
K. King-Collins: in favor
M. Cappuccilli: in favor
S. Romero: in favor
J. Baez: in favor
G. Grannan: in favor
G. Keys: in favor
S. Heaven: abstaining
L. Diaz: abstaining
A. Edelstein: in favor
M. Coleman: in favor
M. Martinez: in favor
P. Gorman: in favor

Motion passed: 15 in favor, 0 opposed, 3 abstaining.

Presentations:

—Epidemiological Report with Kathleen A. Brady, MD—

K. Brady said she would be presenting on the HIPC Data Update for January 14, 2021. The first graphic she presented was a graph for HIV surveillance report of HIV and AIDS Diagnoses, Deaths, and PLWH by year until 2019. She said that in 2019, they started to have declining numbers of PLWH. This was not due to mortalities—and, in fact, mortalities were represented by the blue line which had decreased. She said more that 50% of PLWH are over 50 years old, and that PLWH may be dying from reasons other than HIV, such as aging. Additionally, they are doing better at cleaning up their database for people no longer living in Philadelphia or people who died in the past.

She reported that there was a slight decline in the number of HIV cases, while new AIDS cases were at an all-time low, largely due to less people being diagnosed late. There were more people with longstanding HIV, not progressing to AIDS.

In Philly in 2019, 439 people were diagnosed with HIV, the largest age group being 30-39 years and representing over a quarter of diagnoses. More than three quarters of diagnoses were among men, and 53.5% of diagnoses were among MSM.

Rates among MSM had declined in 2018 and went up a bit in 2019 but still not as high as the 2017 data. This risk group was still much higher in their rates than other risk populations. For PWID (people who inject drugs), there was an outbreak identified in 2018, and the rates had increased since 2015/2016. Rates of new diagnoses among heterosexuals continued to decline. Therefore, there were two priority populations: MSM and PWID.

Regarding race/ethnicity on the slide titled "New Diagnosed HIV by Race/Ethnicity 2019," she explained that the blue bars are actual numbers of people diagnosed in 2019 while the red bar represented the rate of diagnoses per each race/ethnicity based on population size. Most of individuals diagnosed were Black. Black individuals had the highest number and rate of diagnoses (280 diagnosed with a rate of 44.3%), followed by Hispanic individuals (77 diagnosed with a rate of 41.7%), and then White individuals (73 diagnosed with a rate of 13.9%).

In terms of the HIV Diagnoses by Census Tract, 2019 slide, she reviewed the Philadelphia chart. She said there would also be an EMA-wide chart available. The map was broken up by zip code. Please refer to this chart for more detail. As for youth diagnoses in 2019, K. Brady said that 32 individuals were 13-19 years old and 75 individuals were 20-24 years old. In total, 23.2% of those newly diagnosed were considered youth.

As mentioned before, she said that there has been an outbreak of HIV diagnoses among PWID. There were 33 cases in 2016 and 83 cases in 2019. She explained that the diagnoses rate decreased in 2016 and then quickly increased since then. Please refer to the "Number of Newly Diagnosed Cases of HIV (regardless of AIDS status) in PWID, by Year" slide for more detail. She said that this chart did not, unfortunately, show 2020 data. There had been decreases in HIV testing due to COVID-19. Therefore, the number as of the third quarter of 2020 only showed 14 new diagnoses, but she said that this likely meant they were not identifying many cases.

K. Brady referred to the chart on the slide titled, "Current Viral Suppression Status Among PWID by Diagnoses Month" which represented data as of the end of December 2019. The blue bars represented those who were virally suppressed, purple represented those not virally suppressed, and green represented those who had likely *not* been linked to care and had unknown viral suppression. She said that there is a growing amount of purple and green within the graph. She added that they would most likely continue to see growth of transmission in PWID.

K. Brady read the PowerPoint slide titled "HIV Diagnoses in the EMA." In all, there were 701 new HIV diagnoses across the EMA in 2019, 63% of those occurring in Philadelphia. As for late HIV diagnosis (AIDS diagnosis within 3 months person's diagnoses), the data was 1 in 8 with concurrent diagnosis in Philadelphia, 1 in 5 in NJ counties, and 1 in 3 in PA counties. She added that males, Blacks/AA, Hispanics, those aged >40, MSM, and heterosexuals were more likely to be diagnosed late. She said that for the goal for AIDS diagnosis within 3 months person's diagnosis was to reduce it to 1 in 100. For clarification, the PA rate for this was over 30%.

D. D'Alessandro asked if the 1 in 8 with concurrent diagnoses in Philadelphia had this stayed steady. K. Brady responded that this number had reduced, explaining that it was as high as 25% in Philadelphia in previous years, so they had seen greater declines in Philadelphia. D. D'Alessandro asked why bisexuals were not included in the late diagnosis data and if this meant they were at less risk to transfer. K. Brady explained that this data was referencing transmission categories.

M. Martinez noted that the age group diagnosed late is over 40 years old and asked for more explanation around this. K. Brady said that the likelihood increases over 40 and continues to increase the older the population in discussion. She explained that when people get older, medical providers have a tendency to avoid drug use and sexual behavior conversations with patients. Essentially, providers tend to underestimate the increased risk factors in older populations. This, she noted, was purely assumption-based. She added that people who were younger may not have as many additional health issues, so their doctors were more likely to talk about preventative methods and risk behavior. Older individuals may have other medical issues that may distract from prevention and risk in the doctor's office. A. Edelstein added that in Delaware County, traditionally, many individuals do not get identified until they become sick.

Since the onset of the pandemic, K. Brady explained that there were 32 PLWH who died of COVID-19 with highest records occurring in December. Cause of death information may be incomplete, so AACO had discussed doing a match with the overall COVID-19 database sometime in 2021 to get a better idea of how many PLWH contracted COVID-19 along with mortality data. M. Martinez asked if providers should report COVID-19 related deaths to AACO personally. K. Brady responded that if hospitals list COVID-19 on the death certificate, AACO should get the data.

N. Swinson asked if HIV diagnoses was function of testing strategies. She added that in Philadelphia, they tend to test older populations rather than younger populations. K. Brady said that Philadelphia was focusing on testing older populations since so many older individuals are unaware of their status—this is not as much of an issue for individuals under 40 years old.

As for PLWH in Philadelphia, K. Brady read the following data. For race, 63.9% were Black/AA, 15.8% Hispanic, and 16.8% White. Regarding Age, 53.6% were over 50 years of age. Regarding transmission rate, 38.2% were MSM, 34.3% heterosexual, and 19.3% PWID. For gender data, 369 were transgender women and 19 were transgender men. Within the same slide, she noted the chart to the right which contained transmission categories further broken down by race/ethnicity. She explained that rates in both Heterosexuals and MSM transmission were much higher in Black and Hispanic individuals compared to white people.

K. Brady next flipped to a slide titled "PLWH by Census Tract, 2019" which contained a map of PLWH within Philadelphia. She said that HIV is everywhere within the city. She explained that areas that seem to have low numbers of PLWH typically have small populations.

She next brought up a map of PLWH by Zip Code throughout the entire Philadelphia EMA. She noted that Philadelphia is very apparent within the EMA-Wide map, though there were also other places within the EMA that had higher rates. Please refer to this chart on the slide titled "PLWH

by Zip Code Philadelphia EMA, 2019" for more information. There were 27,074 PLWH within the 9 County EMA. 70% of individuals lived in Philadelphia, 2.9% lived in Camden, and 1.7% lived in Chester. She explained that these were the counties with the highest ranking number of PLWH.

K. Brady continued to the next slide, noting that based on the surveillance report, there were 13,960 individuals with indication of PrEP. Most of these individuals were MSM and Black. For PWID, the highest number with PrEP indication were Hispanics. Within Heterosexuals, the highest number of individuals with PrEP indication was Black/African American.

As for PrEP awareness and usage within the surveillance report. K. Brady explained that the National HIV Behavioral Surveillance Project was used to interview people within certain groups about sexual and drug using behaviors, health care, access to prevention services, and conducting HIV testing. They last did an MSM cycle in 2017 and would do a new MSM cycle in 2021. The PWID cycle was in 2018, the Heterosexuals was in 2019, and the Trans women cycle finished in 2020.

K. Brady noted that within the National HIV Behavioral Surveillance data, the light pink bar represented awareness of PrEP which was highest among Trans women, followed by MSM. The highest adherence to PrEP was primarily among MSM and then Trans women. Overall, there was little uptake among PWID and essentially none among Heterosexuals.

B. Rowley asked for the denominator for PrEP adherence and the meaning of the cross next to "PrEP Adherent." K. Brady responded that denominator for the first three columns was the number of people they interviewed, and the "PrEP Adherent" cross was meant to refer people to the definition of PrEP Adherent within the report, itself.

K. Brady next review the "Modified HIV Care Continuum Chart for Philadelphia, 2019" slide. She said that the chart was only based on individuals who had evidence of care within the last 5 years. They examined a total of 14,873 individuals with evidence of care during 2019. She said that these are the people who were also reachable within the EHE effort and could assist with meeting EHE targets.

She next reviewed the slide titled "Philadelphia EMA HIV Care Continuum." She noted that this continuum included the 18,000 people for Philadelphia, so it did not exclude those with no evidence of care within the last 5 years. She highlighted the significant fall in retention in care and viral suppression. Overall, there were many individuals within the surveillance system who were no longer living in the jurisdiction. She said that there was a national effort to improve surveillance data which is why they were using the modified continuum for Philadelphia. The goal was to also have a modified continuum for the entire EMA next year based on new HRSA methodology released in the fall of 2020.

K. Brady referred to the slide, "Dashboard." In terms of how they were doing in terms of EHE targets for 2025. She said that the diagnosis rate had not yet declined, though the proportion diagnosed was on track to meet EHE targets. Care continuum numbers, there was more work to

do for the targets. She said that there were no disparities along continuum except for PWID. They would work on this disparity within 2021, especially for outbreak response. Regarding Transgender women living with HIV (Trans WLWH), there were 369 women. Regarding HIV acquisition, 80% acquired HIV through sex, 18.4% through injected drugs. There were 19 Transgender men living with HIV (Trans MLWH), and 75% acquired HIV through sex. She said that less than one-quarter of Trans WLWH were older than 50, so this was not representative of the the rest of the HIV epidemic and age. In terms of race, three-quarters of Trans WLWH were Black/AA, about 15% were Hispanic, 7.5% were white, 2.7% were multi-racial, and 2.4% categorized themselves as "other."

K. Brady next referred to the slide titled "Philadelphia Prevalence-Based Continuum, 2019." The chart on the right compared Philadelphia and Philadelphia EMA data for the care continuum. Based on the Philadelphia modified continuum numbers, she said, it was expected that the EMA-Wide viral suppression rates were actually 51.6%.

K. Brady next review the slide titled "Philadelphia EMA" which had to do with the EHE initiative. She said that this data was based on the modified continuum of 14,873 PLWH in Philadelphia. Based on this, she regarded the transmission data: 67.4% were virally suppressed and accounted for no transmissions, 9.5% were in care but not virally suppressed and accounted for 25% of transmissions, 12.8% were aware of their status but were not in care and accounted for 36% of new transmissions, and 10.3% were unaware of their status and accounted for 10.3% of new transmissions.

K. Brady shared her contact information for the group to contact her if needed. G. Grannan asked if PWID among Trans women included hormone injections. K. Brady said that no, because if it is prescribed by a doctor, it was not included. However, if someone was buying hormones elsewhere, it would count under PWID.

D. D'Alessandro asked if they collect data around fatal drug injections for PLWH. K. Brady said that there were higher overdose rates of among PLWH who inject drugs than PWID living without HIV. In 2021, they would like to look at trends over time around this information and hopefully publish that data. For PLWH who died of a drug overdose, they would like to identify missed opportunity.

D. D'Alessandro asked if there was tracking information for PLWH infected with COVID-19 who survived. K. Brady said that they can match the data to look at this since there was a database of people testing positive for COVID-19 which could be matched to their own surveillance data base. At this point, with so much data collected on COVID-19, they could look into whether there was greater morbidity and mortality for PLWH and COVID-19. She noted that there was a recent study within the UK that identified greater mortality for PLWH who had COVID-19, but other studies had shown mixed results. This is why PLWH are not included in Phase 1 of COVID-19 as of now. This information was being regularly updated by the CDC.

B. Rowley asked why people were not getting care. As a follow-up, he asked if the problem was at the system-level or patient-level, and from a medication management adherence perspective, how swiftly people were receiving medications. K. Brady said that appointment availability may

be an issue which depends upon each facility. She added that they were prioritizing rapid-ART within 96 hours of diagnosis. She said that it would take effort from testing sites, whether they be community based or in medical settings. When people know that ART is available, they would most likely get patients tested and treated more quickly. They also wanted ensure that providers had availability and open slots. This would be possible with immediate telehealth visits, which would in turn get patients into the office within the same day or within 96 hours. They could then have immediate ART initiation. All of the people newly diagnosed, they want to review medical records to see when ART is prescribed.

A. Williams asked that in terms of access to telemedicine, whether there were resources to ensure newly diagnoses PLWH had access. K. Brady said that there was availability for people to use telemedicine right away. K. Carter asked if they had identified providers that can provide Rapid ART. K. Brady responded that there were some, but this was an ongoing process and was a main goal for 2021.

N. Swinson mentioned that for 72 hour ART initiative, they was a study to understand how this metric could be achieved in CBOs. K. Brady responded that this was looked at a population level but could be done anywhere—if patients can reach a medical provider's office, getting them to ART should be possible. B. Rowley asked if there were guidelines for providers about considerations around Rapid ART. K. Brady responded that there was an assessment tool for providers to use for them to do a self-assessment, adding that the Philadelphia EMA was borrowing tools from other jurisdictions, though it was not ready for full implementation.

The council thanked K. Brady for her presentation.

—3Q Spending Report—

A. McCann-Woods said she would briefly review the spreadsheet for RYWHAP spending through November 30th 2020. This was spending data for end of the 3rd Quarter. Throughout the entire EMA, there was a total of $2,224,282 or 13% underspending of the total award. All spending discussions were limited to over or under a 10% spending threshold.

A. McCann-Woods visited the PowerPoint for the 3Q Spending Report. She said that Reconciliation of total invoices forwarded to AACO for processing through November 30, 2020 indicated thirteen percent (13%/$2,224,282) underspending of our total overall award (includes Minority AIDS Initiative funds). She noted that hospital and the two fiduciary entities (PHMC and UAC) inherently have cumbersome fiscal processes which results in delays submitting invoices and budgets. This has been exacerbated by COVID-19 and remote work.

She read Philadelphia underspending at or above the 10% threshold. There was underspending for Substance Abuse Treatment (Outpatient) for $56,288 due to vacancies (hiring freezes), delayed spending on operating expenses, leveraging other funding, sluggish invoicing due to COVID-19. EFA-Pharma was underspent by $74,997 due to decreased utilization with the underspent funds to be reallocated. EFA-Housing was underspent by $35,816 due to late invoicing, delayed spending on operating expenses, and underutilization. She added that some underspending for EFA-Housing was related to COVID-19. The recipient had expanded

access to the service by way of eligibility. Moreover, additional COVID HOPWA funding had been meeting housing need. For Housing Assistance (Shallow Rent Program), funds were underspent by $117,425 due to late invoicing and underutilization also due in part to COVID-19. She said that for this as well, the recipient had expanded access to the service by way of eligibility. Lastly, there was also underspending within Transportation for $9,031 due to delayed operating expenses, leveraging other funding, and COVID-19 related underutilization.

A. McCann-Woods reported that there was no overspending above the 10% threshold within Philadelphia.

A. McCann-Woods read underspending for PA Counties. Outpatient Ambulatory Care was underspent by $67,503 due to delayed operating expenses and leveraging other funding. EFA-Housing was underspent by $9,540 due to late invoicing and underutilization with the slow in requests for assistance likely due to COVID-19. EFA-Pharma was underspent by $48,965 underutilization of funds which had already been reallocated. Transportation was underspent by $101,978 due to leveraging other funding and underutilization related to COVID-19.

As for PA Counties overspending, Mental Health Services was overspent by $18,648 due to higher utilization. She said she would look further into the higher utilization and report back to the committee, since Mental Health Services was also overspent in the second quarter and even more so in the third quarter.

A. McCann-Woods read NJ Counties underspending. Outpatient Ambulatory Care was underspent by $374,445 due to delayed operating expenses and leveraging other funding. Medical Case Management was underspent by $139,762 due to vacancies, though the underspending was still under review since the underspending was unusually high. Mental Health Services were underspent by $64,560 due to vacancies, late invoicing. She added that, despite filling the vacancy for Mental Health Services in the previous quarter, underspending persisted. Underspending would decrease for this service by the final quarter, and any unspent funds would be reallocated. Substance abuse was underspent by $46,941 due to late invoicing, delayed operating expenses, and leveraging other funding. Food Bank ($6,836 underspending), Other Professional Legal Services ($21,072 underspending), and Transportation ($36,758 underspending) were underspent due to late invoicing, while Food Bank and Transportation were also underutilized due to COVID-19. Oral Health Services were underspent by 24% at $46,941—this was likely due to delayed operating expenses and late invoicing.

For NJ Counties, there was no overspending above the 10% threshold.

A. McCann-Woods next reported on Systemwide underspending. Information &Referral ($427,692 underspending), Quality Management Activities ($76,642 underspending), Systemwide Coordination ($18,972 underspending), Capacity Building ($72,976 underspending), and Planning Council Support ($79,379 underspending) were all underspent due to vacancies, adding that PC Support was also underspent due to a decrease in overhead costs related to remote work. She explained that due to cumbersome hiring practices at the recipient level and a hiring freeze, underspending is a result. Moreover, all underspending has been or would be reallocated to direct service categories.

As for MAI Systemwide Allocations, Outpatient Ambulatory Health Care was underspent by $36,076 due to late invoicing, delayed operating expenses, and leveraging other funding. I&R ($4,779 underspending) and Grantee Administration ($99,641 underspending) were underspent due to vacancies. She reiterated that this was also due to the cumbersome hiring practices at the recipient level and a hiring freeze—all underspending has been or would be reallocated to direct service categories.

A. Edelstein explained that A. McCann-Woods presented this report within the Finance Committee where it was discussed. He ensured that new members of the council knew that review of the quarterly spending reports was one of Finance Committee's ongoing responsibilities.

Committee Reports:

—Executive Committee—
No report.

—Finance Committee—
No report.

—Nominations Committee—
M. Cappuccilli reported that Nominations met today, right before the HIPC meeting. For any new members looking to select a committee, Nominations would be glad to have them. Within the meeting, they looked into the 11 new seated members and attendance. He explained that this was the first time the Nominations reviewed data on HIPC attendance report. The committee looked into who they have had challenges reaching, so they were going to reach out to out-of-touch councilmembers personally to see if they had to modify their policy and standard for attendance.

—Positive Committee—
N. Johns reported that the Positive Committee had a December 2020 Positive Check-in, and they would be next meet January 19th from 7:00-8:00 p.m. During this meeting, they would set their work for the upcoming year. N. Johns put her email address in the chat, nicole@hivphilly.org. She would be sending a follow-up email to everyone with links and resources for today's meeting. She would include the Positive Committee meeting details as well.

—Comprehensive Planning Committee—
G. Grannan reported that CPC would be meeting next Thursday. He said that CPC was glad to accept new members to the committee. L. Diaz reminded the new members that they had to join a subcommittee.

—Prevention Committee—
C. Steib reported that Prevention Committee would meet January 27th at 2:00 p.m.

Any Other Business:

C. Steib said that he would like to bring the Ad-hoc Recruitment Workgroup to a vote in a future HIPC meeting, so they could form the workgroup. L. Diaz asked to put this in the next meeting's agenda.

Announcements:
D. Surplus announced that there was a new ACME HIV Care and Prevention Program on 180 West Girard in Philadelphia and 121 East City Avenue in Bala Cynwood. She reported that these locations would always have PrEP and PEP in stock, she asked anyone to send her an email with any question.

K. Carter announced that Elder Initiative reached their 10-year anniversary, "Cause for Applause," and would being honoring Dr. Rachel Levine and others at 7:00 p.m. tonight. This was a free, virtual event.

M. Coleman thanked Dr. Stanford, Black Doctors COVID Consortium, and PDPH for testing people for COVID-19 in the City of Philadelphia.

L. Diaz said that if anyone had trouble finding a committee, contact office for the right fit. Contact nicole@hivphilly.org.

L. Matus announced that medical linguistic services, telehealth or otherwise, was available. Email her matusl@congreso.net so she could get interested individuals information.

B. Rowley announced that if any agencies were in need of training related to Cultural Humility, he was happy to assist with setting this up.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** K. Carter motioned, C. Steib seconded to adjourn the January 2021 HIPC meeting. **Motion passed:** Meeting adjourned at 4:24 p.m.

Respectfully submitted,

Sofia Moletteri, staff

Handouts distributed at the meeting:

- January 2021 HIPC Meeting Agenda
- December 2020 HIPC Meeting Minutes