# Meeting Agenda

*VIRTUAL:*
*Thursday, January 21, 2021*
*2:00 p.m. – 4:00 p.m.*

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(October 15, 2020)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - COVID-19 Survey Results
    - Literature Review
    - Situational Analysis & Guiding Principles/Pillar Zero
- Other Business
- Announcements
- Adjournment

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

The next Comprehensive Planning Committee meeting is
**VIRTUAL: February 18, 2021** from **2:00 – 4:00 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*

Comprehensive Planning Committee

**Philadelphia HIV Integrated Planning Council**
**VIRTUAL: Comprehensive Planning Committee**
**Meeting Minutes of**
**Thursday, October 15, 2020**
**2:00-4:00p.m.**
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

**Present:** Keith Carter, Sharona Clarke, David Gana, Pamela Gorman, Gerry Keys, Clint Steib

**Guests:** Jessica Browne (AACO), Debra D'Alessandro, Tira Faison

**Staff:** Beth Celeste, Nicole Johns, Mari Ross-Russell, Sofia Moletteri

**Call to Order/Introductions**: K. Carter offered to chair the meeting and called the meeting to order at 2:06 p.m. He asked everyone to introduce themselves with their name, place of representation, and pronouns.

**Approval of Agenda**: K. Carter referred to the October 2020 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** D. Gana motioned, C. Steib seconded to approve the October 2020 CPC agenda. **Motion passed:** All in favor.

**Approval of Minutes:** (*September 17, 2020*) K. Carter referred to the September 2020 CPC meeting minutes S. Moletteri distributed via email. J. Browne corrected the minutes, noting that at the top of page 5, where it says, "J. Browne confirmed that AACO collects gender identity and sexuality data" should be changed to gender identity and sex at birth, not sexual orientation. She explained that AACO's data on sexual orientation is more limited than the data on sex at birth and may not be available in all circumstances. K. Carter called for a motion to approve the minutes with the noted amendment. **Motion**: C. Steib motioned, G. Keys seconded to approve the amended September 17, 2020 meeting minutes. **Motion passed**: All in favor.

**Report of Chair:**

None.

**Report of Staff:**

N. Johns reported that the COVID-19 survey launched today. It was live and had social media assets to help advertise the survey. You can find these resources on hivphilly.org/covid-19. There were also survey links for the English and Spanish language versions. OHP depends greatly on both community and provider relations to help distribute the surveys. OHP would also mail out paper surveys by request with postage-paid return envelopes for both individuals and agencies.

N. Johns also reported that on November 11th, there would be another HIPC open house. She would send out more information about the open house via email.

Lastly, N. Johns reported that OHP was hosting their fall training series. The next training about improving systems of care would be next Friday. The trainings were to run every other Friday from 12:00 – 1:00 p.m. until the first week of December 2020. The information can be found in OHP's Facebook events or the OHP website. You can register for one or all of the trainings through one link.

**Discussion Items:**

***—COVID-19 Marketing and Distribution—***

N. Johns said that this committee was instrumental in developing the questions for the COVID-19 survey. Now, CPC would need to assist in the distribution of the surveys. As stated in the staff report, the marketing materials are available on the OHP website. If anyone needed help with crafting an email about the survey, they could refer to the office with phrasing questions or simply forward any materials from OHP.

The survey was available in both Spanish and English. The Spanish version was reviewed and edited by HIPC members to ensure the language was accessible and understandable. OHP would mail out paper surveys by request. Requests were better made sooner than later due to any COVID-19 delays, especially with remote work.

The purpose of the survey—open until December 15th—was to help HIPC understand the impact of the COVID-19 pandemic on RWHAP clients. There were many questions from HIPC about COVID-19 and its impact within the allocations planning process for the fiscal year starting March 1st, 2021. The survey asked about people's COVID-19 exposure, how service delivery/access has changed, housing, income, mental health, and general demographic information so they can note any disparities.

She said the data from the survey would go to the council and the analysis should be finalized by February 2021. The council should have both the COVID-19 survey data as well as final grant award information. This data could help to inform any changes the council would want to make for the final allocations decisions for FY 2021. This could also inform other planning throughout the year.

N. Johns explained that it was important to get to communities most impacted which is why it was necessary for providers and community members to work hard to distribute the surveys to reach all audiences. She said that she would hopefully offer results of the COVID-19 survey throughout the process. They could also work on target distribution for the survey if they saw they were not receiving answers from populations needed.

C. Steib said that on the website, there were printable flyers that still had "link in bio/description" on them. He noted that this would need to be changed for printable flyers. S. Moletteri said that she would fix this. C. Steib asked if she could alter the flyers to have the link so people could take pictures of the link to type in later. S. Moletteri said that she would.

***—Integrated Plan Monitoring—***

N. Johns said that CPC started talking about the Integrated Plan last month. They are towards the end of the 5-year plan written in 2016. This was the very first Integrated Plan, since before this, there had been two separate plans. In 2018, the plan was updated with baseline data.

CPC would focus on the RW-related activities, while Prevention Committee would focus on testing, PrEP, biomedical prevention, etc. within the Integrated Plan. Once there is federal guidance from HHS and CDC about what the new Integrated Plan should look like, they could begin to develop the next 5-year plan.

N. Johns said that the plan was also changeable, and in 2018, they changed and added activities since funding, policy, community, and needs change throughout the years. As they went through the update, she asked that the committee think about accomplishments as well as any necessary changes. Some portions within the plan were ongoing while other portions involved short-term initiatives or programs.

N. Johns reviewed the monitoring process. She said that they would need to make a data request to AACO and other stakeholders around data indicators within the plan. This was in process, and the data would be available to review within a few months. Today, the committee would walk through the plan together and this could act as a refresher for older members and an introduction for people new to the plan and the committee. While reviewing, she emphasized the need to note any changes, accomplishments, improvements, concerns, and appropriate recommendations/plans. N. Johns said that these suggestions would be best for informing the next 5-year plan, though everything, including plan guidance, had been delayed due to COVID-19 as of now.

N. Johns explained that the Prevention and Care Comprehensive plans informed the Integrated Plan, so the past Integrated Plan would inform the next as well. She brought up Goal 2 for CPC to review, since Goal 2 was in the committee's purview. Everyone agreed to reviewing Goal 2. N. Johns explained that Section I of the plan has the epidemiological overview, the care continuum information, as well as the resource inventory. Section II of the plan contains the goals, objectives, and strategies. All of this information is on the website.

The goals are written based on the National HIV/AIDS Strategy. Therefore, these goals may seem familiar. She said that Goal 1: Reduce New HIV Infections was a prevention related goal. The first objective, she stated, was to increase the proportion of people who know their HIV status. After that, there are strategies and activities to support the objectives.

N. Johns scrolled to Strategy 1.2.3., to ensure equitable access to syringe access services, substance use treatment, and related harm reduction services. She would review this strategy as an example for how to understand the tables. At the left, there are responsible parties for each activity. Moving across, there are the activities listed with their target populations. Next, they

have data indicators to help indicate progress for the activity. After that, there is baseline 2016 data for comparative purposes regarding the data indicators.

K. Carter asked about what should happen if the access for syringe service goes away under a new administration. He asked if they would need to keep this in mind when crafting a new plan. N. Johns responded that this was always important to keep in mind, especially for criminalized items which may have changes in legislation and enforcement. Such changes, of course, would also be noted in the plan and planned for accordingly.

N. Johns briefly reviewed other activities from Strategy 1.2.3., noting that some of the data had still not been reported/updated as of the 2018 update, specifically the data around number of persons receiving Medication Assisted Treatment (MAT) at RW medical providers offering MAT. M. Ross-Russell asked J. Browne if this data was currently being gathered. J. Browne said that data should be collected under CAREWare and RSR.

N. Johns scrolled to Goal 2 of the plan, highlighting Goal 2 as a care-centric goal. Goal 2, she read, is to "increase access to care and improve health outcomes for people living with HIV." She read the first objective, Objective 2.1, as well: Increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis. She also read the first strategy, Strategy 2.1.1: Reduce individual and programmatic barriers to care. She said that this goal would have a trend, with the topics looking at programmatic and systemic barriers.

Recurring themes are "expand" and "continue" for this goal, because a lot of these activities are ongoing or beginning at the time of the plan. Some activities were also available within the EMA but not across, hence "expand." She clarified that some resources and politics can change based on the jurisdiction within the EMA, so some services required more work to make equitable and accessible.

K. Carter noted that, across the EMA, they have improved upon getting newly diagnosed people into care within the 30 days. N. Johns agreed, reminding the group that this is important to note while they monitor progress. She said that they have met this, and within the next plan, the timeframe may be reflected in new goals. C. Steib added that the 30 days is based on CDC criteria. This timeframe used to be 60-90 days, but this now follows the CDC's recommendation of 30 days.

N. Johns said that the first strategy focuses mostly on linkage to care, programs, and whether clients can physically get to appointments. N. Johns reminded the group that measuring progress can sometimes be difficult, so they have to work with the data they had for the last plan. For example, seeing if support services were available, the plan indicated that this can be measured through the percentage of RW Part A funds used. They can always strategize new ways to measure.

N. Johns summarized strategies 2.1.2 and 2.1.3. Please refer to page 11 of the Integrated Plan Section II 2018 Update for more information.

N. Johns next read Objective 2.2: Increase the percentage of people with diagnosed HIV infection retained in care by—Strategy 2.2.1—reducing individual barriers to retention in HIV care. This meant that they were looking at more information on the individual level to deal with case-by-case situations (for example, ensuring client access to medical case managers). As for care coordination and co-locational services, based on a plethora of studies, they are proven to be helpful to individuals in reducing barriers.

Also under strategy 2.2.1, N. Johns explained that behavioral health services often comes up within activities to ensure people have access to appropriate services and are being screened properly. She then defined HAB, explaining that it was an acronym for HIV/AIDS Bureau. HAB numbers outcome measures, which explained HAB16 and HAB17 below the 2016 baseline data in strategy 2.2.1.

Concerning COVID-19 and surrounding delays, K. Carter asked if HIPC would be able to receive the interim analysis when needed. N. Johns said that they would, since data would be from 2018 and 2019. There may be delays, but they would likely get everything in time.

N. Johns reviewed Strategy 2.2.2: Reduce programmatic and provider barriers to retention in HIV care and Strategy 2.2.3: Reduce systemic barriers to retention in HIV care. N. Johns added that PA is the only state within the country whose RW Part A program does not provide insurance cost sharing assistance through the ADAP program. Please refer to page 13 of the Integrated Plan Section II 2018 Update for more information.

N. Johns read Objective 2.3: Increase the percentage of people with diagnosed HIV infection who are virally suppressed as well as the first strategy: Reduce individual barriers to treatment adherence. They looked a lot at food access, especially in NJ, as well as MCM access. She noted that the model for MCM has since changed since the 2018 update, so these changes may be reflected in the new plan. Please refer to page 14 of the Integrated Plan Section II 2018 Update for more information.

N. Johns then looked at Strategy 2.3.2: Reduce individual barrier to ART. N. Johns noted that the SPBP program in PA is now much faster with enrolling individuals. This has made reliance on local pharmaceutical programs decrease, so they have been able to reallocate this funding. She explained that numerical indicators do not necessarily mean that progress has not been made, adding that there are numerous reasons units may decrease. Please refer to page 15 of the Integrated Plan Section II 2018 Update for more information.

N. Johns briefly summarized Strategy 2.3.3: Reduce systemic barriers to ART. Please refer to page 15 of the Integrated Plan Section II 2018 Update for more information.

N. Johns next read Objective 2.4: Increase the percentage of PLWH retained in HIV care who are stably housed. She explained that the committee has been working on and discussing housing for the past year, and some recommendations from CPC have been implemented regarding EFA. This would likely be reflected in the new plan. She summarized strategies 2.4.1, 2.4.2, and 2.4.3. Please refer to page 16 of the Integrated Plan Section II 2018 Update for more information.

Moving onto the third goal: Reduce HIV-related disparities and health inequities, N. Johns read the first objective, Objective 3.1: Reduce HIV-related disparities in new diagnoses among high-risk populations. In the past, she said CPC spent time on Strategy 3.1.3: Provide services that address social and behavioral health needs of people living with HIV that promote treatment adherence and HIV prevention. Please refer to page 19 of the Integrated Plan Section II 2018 Update for more information.

N. Johns next read Objective 3.2: Reduce disparities in viral suppression and Strategy 3.2.1: Continue RW-funded activities to retain in medical care and achieve viral load suppression for priority populations. She read the correlating activities. Please refer to page 20 of the Integrated Plan Section II 2018 Update for more information. J. Browne noted that AACO had temporarily discontinued the Disparity Focused Quality Improvement projects due to COVID-19 and other factors. She said that they were, however, revamping their QM program for both COVID-19, and disparity focused projects may be incorporated.

N. Johns next read Strategy 3.2.2: Encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, PWID, people experiencing homelessness and people with limited English-proficiency and health literacy. Please refer to page 21 of the Integrated Plan Section II 2018 Update for more information.

Goal 4, N. Johns said is about collaboration and coordination which is a lot of OHP's purview, since OHP connects community, providers, and health departments. She briefly reviewed the strategies under Goal 4. Please refer to page 23 of the Integrated Plan Section II 2018 Update for more information. She added that, regarding Strategy 4.2.2, they were to increase integration, communication, amongst the existing planning bodies. This strategy, of course, was achieved through the integration of HIV Prevention Planning Group (HPG) and the RW Part A Planning Council to create HIPC.

K. Carter asked for clarification on what RWHAP covers regarding housing needs. He thought this would be beneficial to make clear to the full council. N. Johns said that they could outline this for the full council, but she reminded the committee that RWHAP mostly provides housing through Emergency Financial Assistance. M. Ross-Russell explained that they started looking at other jurisdictions to see how they provide housing, because they were concerned about "what happens if RWHAP is not able to support a person any longer" due to the short-term housing nature of the program. The goal, then, for RWHAP is to look at other funding streams and at RWHAP's own housing abilities to see how they can support people and prevent homelessness. K. Carter thanked M. Ross-Russell, and added that RWHAP is for temporary, short-term, or transitional housing purposes. T. Faison agreed with M. Ross-Russell, noting that so many housing programs became unsustainable because they could not manage the expense in the long term.

***—Elders Needs Assessment—***

N. Johns said that they are just at the beginning of the needs assessment and only briefly discussed the questions they want to ask at the last meeting. She revisited what the process was

to be for achieving the needs assessment. First, they would gather data from local sources, or data that is already known to HIPC (RWHAP data from AACO, MMP data, general population data, etc.). This will help to create a snapshot of the jurisdictions, needs, challenges, resources available, etc. for aging populations.

As far as the definition of the problem, N. Johns said that there is an aging population for PLWH because of advances in medical technology as well as a general population that is aging. This will only increase as people start to live longer with adherence to treatment as well as younger individuals also aging into this population. As people age, they develop more comorbidities, mobility issues, and social support issues.

They will then do a literature review to uncover what others are doing, interventions and services that support these individuals over time, and changes in needs of the service delivery system. She said that for the needs assessment, they need to look at available resources for aging PLWH and where they are or especially, where they are not. They will need to discuss more about hospice, respite care, etc. and how they are funded within RWHAP.

They will also take surveys, use focus groups, do interviews, and have town halls to collect more data. Once all the data that they will need is collected, CPC will then analyze the data and make recommendations. These recommendations will be brought to HIPC and AACO and then shared with the community and federal partners.

M. Ross-Russell said that the takeaway for this needs assessment is that it will take a while to go through all of the pieces to figure out which information is most valuable and what the Planning Body can impact. For example, any specific Medicare-related issues would be out of HIPC's purview. M. Ross-Russell said they will be working on the needs assessment for a long while due to the fact that it is such a large undertaking.

K. Carter mentioned that CPC could review the PA State Aging Plan in the future. On top of this, the Philadelphia Corporation for the Aging recently made a 5-year plan. Since these are available, these could be a starting point for data gathering. They should also talk to groups/people they have connected with before such as D. Griffin and H. Zinman who have expertise in the subject. N. Johns said that as they move forward, they should be inviting more people to the conversation that have relevant expertise and lived experience. This would also be good for advocacy to ensure that needs of PLWH are reflected within plans that affect larger systems.

N. Johns added that the COVID-19 survey should also give relevant information that could act as a data set to inform the Elders Needs Assessment. She added that the consumer survey is also approaching, so they could tailor questions to individuals who are 50+ years of age. The mean age was 52/53 from the last consumer survey, so this information could also be helpful.

**Old Business:**
None.

**New Business:**

None.

**Announcements:**

M. Ross-Russell announced that towards the end of September, there was a new Executive Order that banned racial sensitivity training under the use of federal funds.

**Adjournment:**

K. Carter called for a motion to adjourn. **Motion**: C. Steib motioned, P. Gorman seconded to adjourn the October 2020 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:27 p.m.

Respectfully submitted,

Sofia Moletteri, staff

Handouts distributed at meeting:

- October 2020 CPC Agenda
- September 2020 CPC Minutes