Meeting Agenda

VIRTUAL:
Thursday, February18, 2021
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(January 21, 2021)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - COVID-19 Survey Writeup
    - Integrated Plan Data & Situational Analysis
- Other Business
    - Next Steps
- 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: March 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, January 21, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Allison Byrd, Keith Carter, David Gana, Pamela Gorman, Gus Grannan, Gerry Keys, Kailah King-Collins

Guests: Jessica Browne (AACO), Debra D'Alessandro, Krista Hein, Blake Rowley, Nicole Swinson, Adam Williams

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

Call to Order/Introductions: G. Grannan called the meeting to order at 2:03 p.m. and asked everyone to introduce themselves with their name, place of representation, and pronouns.

Approval of Agenda: G. Grannan referred to the January 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. D. D'Alessandro asked if participants could vote if they were not officially appointed to the council. N. Johns said that each committee made their own rules, and within CPC, committee voting participation was open to everyone, not just HIPC members. **Motion:** K. Carter motioned, D. Gana seconded to approve the January 2021 CPC agenda. **Motion passed:** 82% in favor, 18% abstaining. The January 2021 CPC agenda was approved.

Approval of Minutes: (*October 15, 2020*) G. Grannan referred to the October 2020 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the October 2020 minutes. **Motion**: D. Gana motioned, K. Carter seconded to approve the October 15, 2020 meeting minutes. **Motion passed**: 56% in favor, 46% abstaining. The October 15, 2020 CPC minutes were approved.

Report of Chair:

None.

Report of Staff:

—Integrated Plan Update—

N. Johns introduced herself as the Senior Health Planner and OHP staff person supporting the committee. She explained that, previously, the committee discussed the 5-year Integrated Plan coming to a close in 2021. They were in the process of collecting data from AACO and other entities for the data indicators. It was likely that most data would be collected by February and could be reviewed during the next meeting. They could have a discussion around the baseline data from 2018/2019, in terms of what they might like to focus on in the future integrated plan.

—Housing Proposal—

N. Johns noted that S. Moletteri assembled a document that outlined the Housing Proposal process developed by CPC. This document contained the different conversations around homelessness prevention and housing assistance within the RWHAP Part A system. This was a documentation of work from CPC and showed how, from this work, CPC developed the Housing Proposal approved by the full Planning Council at the end of 2019. This proposal reviewed what the committee considered, the populations the committee wanted to prioritize, etc. This document offered a concrete example of the type of work CPC did. She also noted that the Housing Proposal was a model for the shallow-rent program under CARES.

Discussion Items:

—COVID-19 Survey Data Review—

N. Johns brought up the Data Dashboard for the COVID-19 Survey. This survey had recently closed and was open from mid-October 2020 until Monday, January 18, 2021. The survey was for PLWH and contained questions about experiences during the pandemic such as exposure, impact on access to treatment, other services, mental health, finances, housing, etc.

Overall, there were 49 responses. Generally speaking, the responses were fairly representative of the EMA, though many responses were from Philadelphia. The survey was available in both English and Spanish, though there were no responses in Spanish.

N. Johns reviewed the dashboard. The first question asked if the respondent had close contact with someone diagnosed with COVID-19 since last February 2019. Only 8 of the 49 people said yes while 20% did not know and 60% said they had not. Next, 4% of respondents, or two people, had been told that they had COVID-19. For those who answered the question about receiving a COVID-19 test, 13% had received a positive COVID-19 test which was again, two respondents.

D. D'Alessandro asked about the question, "Since February 1, 2020, have you been told by a doctor, nurse, or health care worker that you had COVID-19?" She asked about the redundancy between the question about being told that you were positive for COVID-19 and the question regarding testing. N. Johns responded that the reason for this was that the committee added questions from Medical Monitoring Project (MMP) for comparative data. The wording had to be verbatim to MMP for comparison reasons. The question about testing was more about gauging people's ability to access testing. Since 15 people answered the question about testing, this meant that 15 respondents sought out COVID-19 tests. Therefore, this uncovered not many respondents believed they needed a COVID-19 test.

N. Johns next looked over the question about medications. It asked if since February 1st, the respondent had missed HIV doses because of COVID-19. Since there may be many other reasons to miss medications, so this question was specific to COVID-19. Out of 46 respondents, 6 people said yes, meaning the majority did not miss their medications.

Regarding income, the survey asked if people had lost wages for 1 week or more due to COVID-19. Slightly more than half (57% and 26 respondents) responded that their wages were not affected, but 22% or 10 people had COVID-related wage loss and 17% or 8 respondents said the question was inapplicable since they were not working.

There were two questions around attaining prescriptions. One question asked if people had issue getting prescription or refill of HIV medications due to COVID-19. 91% of respondents or 42 individuals had no issues and only 4% or 2 people had troubles. The other question asked about attaining prescriptions of other essential medications, and almost 90% said they had no but 4 people or 9%, said they had no issue.

The next question asked whether respondents had missed any medical appointments. About a third of respondents or 15 people had missed a medical appointment due to COVID-19. A third of respondents also answered "yes" to the question about whether people had any delayed labs since Feb 1, 2020.

Related to access, the survey asked if respondents had any virtual visits. Over 75% if people said that they had and about 20% said no, they had not. She noted that there was no follow-up to this question, so there was answer as to "why" the 20% had not had a tele-visit.

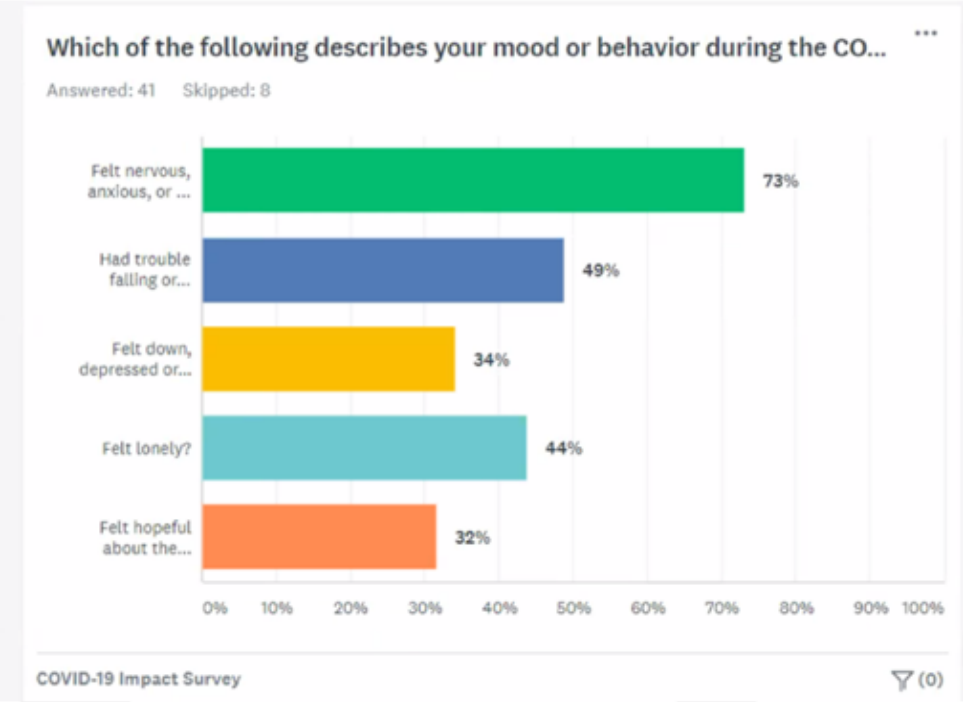
The next question asked if people had been able to receive other services that were not medical services due to COVID-19. About 28% said yes and 67% said no. N. Johns mentioned that this data could be compared to the MMP data for further analysis.

Regarding income and access, the survey asked if since February 2020, the respondents were worried about or had problems with paying for necessities (rent, mortgage, food, etc.). The responses were somewhat split 43% saying yes and 54% saying no.

Specifically looking at three big services—transportation, medication, and food—15% of respondents had issues with transportation, 15% had issues with food, and 11% had issues medication. 72% of respondents had no issues with any of the services. This question had a follow-up for open-ended response, so they could dig into the responses and reasons why as a committee. One respondent reported that their pharmacist had run out of HIV medications for 2 months. Transportation, she noted, was a big issue for people, since they did not want to take transit due to the virus. Furthermore, day passes were harder to get access to because of mail delays, etc. She added that, at the beginning of the COVID-19 response, busses and trains were not running or not running as often.

The survey also asked people about their mental health and mental wellbeing. 37% of respondents said they rarely felt lonely, and 35% said they felt lonely about half of the time. She said the committee could choose to talk more about social isolation given the responses to the survey.

N. Johns pointed to the next MMP question, which asked more specifically how people felt during COVID-19. The answers were as follows:



K. Carter noted that these answers were directly related to your mental health concerns. N. Johns said that, with the next question, answers were almost evenly split regarding support groups. Almost 30% said they had not attended a support group but would like to.

At the end of the survey, there was an open-ended question asking people to share any concerns, questions, or comments about care-related issues and COVID-19. Respondents had concerns and questions about the COVID-19 vaccine. People also brought up mental health services and how accessing these services was difficult due to high demand. People also mentioned rent in the section. To summarize, N. Johns said that within the 49 responses, there were transportation challenges, issues with access to mental health care, and as always, housing insecurity and especially fear around housing and rent because of lost income.

K. Carter mentioned that individuals were not accessing rental assistance and was an underutilized service, yet this survey uncovered that people are concerned about rent. K. Carter also noted that there was a Spanish translation of the survey, yet there were no Spanish responses. He asked what responsibilities Spanish ASOs had with distributing the survey. N. Johns said that this survey distribution may have been challenging since service delivery was very different in the time of COVID-19. She suggested that some organizations/provider may be overextended and the system had changed in regards to interactions with clients.

N. Johns added that there was a question they did not see on the dashboard about MCM. The survey asked if there were any problems with communication with a MCM. Almost 75% said no, and 10% did not have a MCM. They do not know why these people did not have an MCM. 2 respondents had a difficult time with MCM contact. These respondents tried to call and but did not receive any responses or the MCM was not taking appointments. G. Grannan asked if in the demographic breakdown of the responses, there was a question about how long individuals had

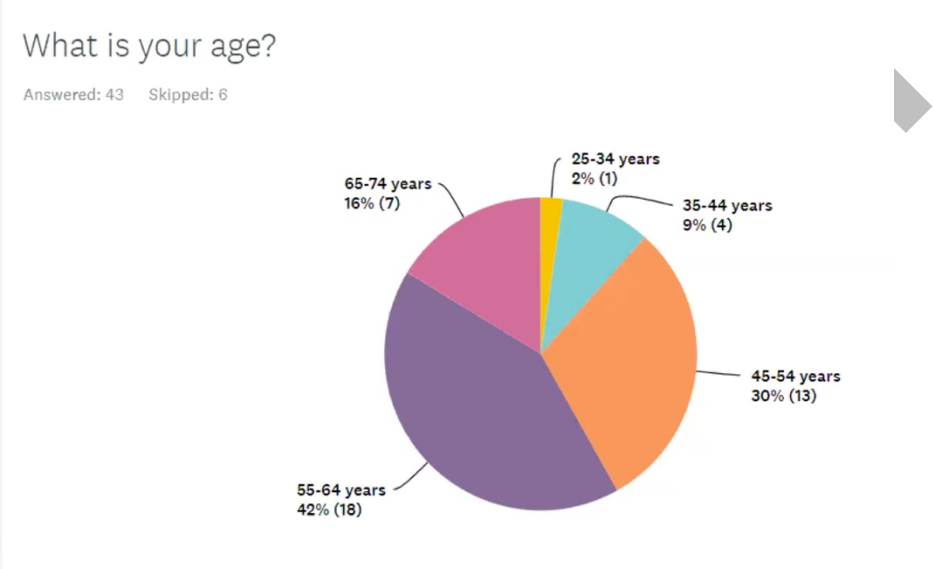
been in HIV treatment. He explained that this could shed light on why 10% of respondents did not have a MCM.

N. Johns said that, as for support groups, the survey asked individuals to describe their experiences. Respondents said that they were still accessing 12-step meetings if this was something they were attending before COVID-19. Generally, people preferred in-person meetings but felt that virtual was better than no meeting. N. Johns said that these responses spoke to the fact that they know individuals want and need social support.

N. Johns gave a demographic breakdown of response: 5% said American Indian or Alaskan Native, 2% said Asian, 47% said Black or African American, 40% said white, 7% preferred not to say, and 5% said other. In total, 39 individuals said they were not of Hispanic/Latinx origin.

As for gender, ¾ of respondents were male, ¼ were female, and one person was transgender. As for sexual orientation, 64% of respondents identified as gay or lesbian, 26% straight, and then smaller percentages for the other categories.

N. Johns said there was a good mix of age. She highlighted that there were only five people younger than 44, so they could have done more outreach for younger individuals, however the ages were fairly representative of the HIV community. The responses were as follows:



For the question about housing, N. Johns said that no respondents lived in a car, shelter, SRO, or the street within the last 12 months. This, of course, was good news but also meant the survey did not reach anyone who experienced this within the past year.

The survey then asked people if anyone had moved in—temporarily or permanently—with another person due to financial problems, and two respondents said that they had.

Next, there was a question about whether people predicted that their housing situation would change within the next six months. 9% or 4 people responded that their housing might change in the next 6 months. 26% said that they did not know.

If housing was likely to change, the survey asked the respondent to further explain. Responses included the follows: either the buildings sold or people felt unsafe in their current building (for COVID-19 or management reasons). N. Johns noted that there was a large variety of zip codes within the responses, so the answers were fairly representative of the Philadelphia area.

Next, for the question regarding employment, 42% or 18 respondents were employed for wages, 1 person was self-employed, 2 people were out of work for more than a year, 4 people were out of work for more than a year, 4 people were unable to work, and 10 people were retired. 4 people preferred not to say.

The survey also asked a question about caregiving for children, elders, or others. 72% said they were not a caretaker but about 25% said that they were. For clarification, many of respondents who were caretakers were caring for their parents.

As for income, the survey asked people about their income. Overall, there were more respondents with higher income. She thought this was important to consider when looking at other responses. 10% of respondents did not answer.

N. Johns said that, based on the survey, 33% of respondents had private health insurance through their employer or a family member's employer, and 10% had private insurance through Healthcare.gov or the Health Insurance Marketplace. 43% were insured through Medicaid and 45% through Medicare. 38% of responded had coverage through RWHAP or ADAP (also known as ADDP or SPBP).

N. Johns introduced a Slido to ask what people they had learned or any questions they had about the COVID-19 Survey. The Slido was titled "What did you learn from the COVID-19 Survey?"

P. Gorman said that her takeaway was that there were a decent amount of mental health and emotional health concerns related to COVID-19. She suggested that they further investigate in the future and consider what exactly they should evaluate around this topic.

There were two anonymous comments in the Slido: "I think the survey was valuable because it helps inspire other questions we need to be asking," and "People are having problems that could be considered related to mental health and housing." N. Johns mentioned the survey's open-ended responses which reflected how respondents may have had deep concern around mental health.

K. Carter noted that there were not enough workers to provide mental health services to clients. He asked if the council could help to make the onboarding process better. P. Gorman said that at her place of work, she noticed that with having to resort to remote access and telemedicine, there was much less uptake for behavioral and mental health services. Her second observation, she said, was anecdotal, but she noticed that many people refused the services. P. Gorman said that people may want these serviced but become hesitant to use them.

K. Carter said that with mental health, telehealth has a possibility of feeling much more surface level and less effective than in-person sessions. He suggested that this caused people to become hesitant to respond honestly or talk about their issues. P. Gorman agreed. She added that because of COVID-19 and social isolation, they should focus on this information and figure out solutions.

A. Byrd said within her practice, they set up times for clients, and noticed that some clients may have relapsed and were suffering from substance abuse once again. This may be a reason for why clients may not show up for appointments. D. Gana said that depending on demographics of the group, older people may carry a stigma around mental health. A. Byrd mentioned that it was the younger population in her practice that missed appointments, as they were typically between 30-40 years old.

G. Grannan said that for medical care, this is also true and is much more utilized by people who are older. He acknowledged that this issue was not completely unique to mental health. He suggested that as people get older, they are forced to acknowledge their body's shortcomings and try to address them with increase medical attention.

A. Williams said that, from his perspective as a past MCM, he heard a lot of feedback around mental health and trust. Clients tended to not trust their providers based upon their own past negative experiences with providers who did not relate to their identities or problems. N. Johns agreed, saying that people may be reluctant to get involved in the service again, especially if they had a bad experience in the past. D. D'Alessandro said there was still a fair amount of stigma around accessing mental health services. She said that this was a major barrier for patients and not specific to HIV patients. G. Grannan said that he thought the clinical protocols were based on assumptions that may not hold for telehealth—for example, scheduling follow-up appointments.

J. Browne wondered whether there was a difference in experience between platforms e.g. video conference vs. phone call. She felt that seeing people face-to-face (video call) might be better, though this may bring up technological barriers. One of the advantages to having virtual visits, she said, was that people did not have to worry about transportation. However, the clients would also have to find somewhere private to talk and are without the benefit of a private clinician's office.

P. Gorman said that regarding support groups, her agency was hosting virtual Zoom meetings and would have about 6 attendees instead of their usual, in-person 10 or 12 attendees. Based on feedback, the group wanted in-person contact. Therefore, prior to the last COVID-19 surge, they hosted a meeting in a large conference room to abide by social distancing practice. Attendees enjoyed this meeting.

P. Gorman added that as soon as people have the opportunity, that people research the vaccine and receive it as soon as possible. M. Ross-Russell said that the state of PA had added PLWH to list of individual receiving the COVID-19 vaccine now. However, in Philadelphia, this was not the case, but she would further investigate this.

D. D'Alessandro said that Philadelphia was dealing directly with the federal government while the rest of PA was going through PA Department of Health. K. Carter added that Philadelphia

also did not know how many vaccines they would receive from week to week. D. D'Alessandro said more specific guidance from the federal government might improve this. K. Carter said that every jurisdiction was different and there were many different vaccines with different efficacy rates. He was concerned that this would cause disparities in vaccine distribution and uptake.

—Overview of Elders Literature Review—

J. Henrikson presented her Aging with HIV literature review. Since she started the literature review in November 2020, she had been collecting research uncover key themes and findings around HIV and aging.

During this presentation, she would look at the research questions, key articles for literature review, areas of further investigation, and existing services within other EMAs.

Because of advancement in treatment options, there is a large population of people getting older with HIV. About 51% of PLWH in the USA were over 50. 15 years ago, HIV was first seen as an epidemic that affected the youth, and this perspective greatly shaped HIV services. From 2014-2018, new HIV diagnoses in people 50+ decreased but still averaged as 1 in 6 new diagnoses. 50+ individuals were less likely to discuss sexual activity with their healthcare provider which could be attributed to stigma around HIV and sexuality. This may also have to do with lack of education around HIV. She said individuals who were 50+ were more likely to have increased immune system damage and late-stage HIV as well as have co and multi-morbidities.

J. Henrikson directed attention to a chart from the CDC. She said that this chart was based on 2018 data and represented every 100 people aged 55 and older with HIV. 71 received some HIV care, 57 were retained in care, and 64 were virally suppressed.

She said that her goal of the literature review was to figure out how the CDC HIV data compared to medication and treatment management for the general aging population living without HIV. This way she could compare how older populations were retained healthcare and if there was a difference between those with and without HIV.

She read her two research questions: (1) What are the resources and services available for PLWH over 50 years old? How do these factors compare for those without HIV in the same age group? (2) How do resources and services available to PLWH over 50 vary across different EMAs?

She explained that access to care can differ with demographic factors (age, economic status, etc.) She reiterated that HIV status can be heavily linked to stigma, it can be a barrier to accessing complementary care, and can affect symptoms and prognosis of co and multi-morbidities.

She explained that there was less research on the impact of an HIV-status in conjunction with demographic factors. For example, for a low income and uninsured individual, does an HIV+ result increase or decrease ability to access care? Does this individual become eligible for more funding programs and increase participation in services?

J. Henrikson addressed the "over 50" question and why age was not broken down further and 50+ was generally considered the "elder population." In mostly all of the research, the research designated over 50—or sometimes over 55—as the elder population. For the purposes of comparing research, she had to stick with 50+ as the category for aging populations. Outside of HIV research and within general population research, researchers sometimes identify this "elder population" as later in the course of life. Therefore, comparing those with and without HIV may present itself as an issue when comparing data.

She said that there were two articles that focused on the state of aging globally and within the U.S. She said that the first article "The Changing Face of HIV: Addressing Health Needs Across the Life Course" gave a general overview of current state of the issue and recent funding and health initiative efforts. She said that this article focused on global efforts with most examples using low and middle-income countries. It established the connection between PLWH over 50 and increased noncommunicable diseases. She said that it never compared the experience with general 50+ populations to 50+ populations of PLWH. However, the article did end with active suggestions such as further research, increased advocacy, and more focus on the voices of 50+ PLWH.

The second article, "Aging with HIV" within the *Journal of the American Society on Aging.* She said that this article covered the heightened risk of co and multi-morbidities for PLWH as they aged. It also discussed challenges and barriers with historically youth-geared services and lack of familial support for LGBTQ+ PLWH. She said that it discussed managing multi-morbidities, pitfalls of current care system and the argument to increase funding for social services. This article did not provide much direction on where to bolster funding or provide sustainable solutions.

The next article, "A systematic review of psychological interventions for older adults living with HIV" more directly addressed key issues facing PLWH over 50 years old. She said that this article examined existing research on interventions aimed at improving psychological / psychosocial wellbeing of PLWH over 50. She said that this article focused on nonmedical interventions. Most importantly, this article was recent and published in 2020. There were intervention statistics and outcomes. The article suggested more rigorous studies as the aging population increased.

She explained that the next article was also published recently, in 2021 and was similarly thorough to the last article. This article, titled "Aging with HIV: Health Policy and Advocacy Priorities," focused on policy and advocacy priorities as well as socio-demographics and its effects on PLWH over 50. In other words, the article dealt with stigma of sexuality and HIV, systemic and interpersonal racism, etc. This article covered accelerated aging for PLWH (since PLWH tend to face other health complications at younger ages with co and multi-morbidities). It also covered social isolation. It ends by suggesting fortifying healthcare systems informed by geriatric care models and a more dedicated focus on mental health services. There was also an overarching call for service providers to work on cultural competency.

She said that the next two articles were the best articles she could uncover that dealt the comparison between PLWH to the general population. The articles were titled "Cross-sectional

Comparison of the Prevalence of Age-Associated Comorbidities and Their Risk Factors Between HIV-Infected and Uninfected Individuals" and "Do Patterns of Comorbidity Vary by HIV Status, Age, and HIV Severity?"

The first one, "Cross-sectional..." did a cross-comparison of about 600 PLWH and 550 uninfected controls to test if PLWH were at higher risk of comorbidities compared to uninfected individuals. It found that risk of age-associated noncommunicable comorbidities (AANCCs) was independently associated with age, genetics, smoking etc., and also HIV infection. It did not address social factors or care procurement/adherence. It concluded by finding that AANCCs were more prevalent among PLWH compared to uninfected controls.

The final article, "Do Patterns..." was from 2007, so it was an older article. It compared comorbidities among veterans with and without HIV with a sample size of 33,420 PLWH and 66,840 uninfected peers. It found that older HIV-infected veterans had higher risk of substance use disorders and multi-morbidities. In contrast to other research, she said, among this population, HIV-infected veterans had lower risk of hypertension, diabetes, vascular disease, and psychiatric disease than uninfected peers. However, HIV positive veterans did have increased risk of liver disease, renal disease, substance use disorder, and multi-morbidities. The data identified shortcomings in their analysis, stating that data stratified quickly based on which demographic they clustered.

She said she would like to find more research on social and mental health services for PLWH over 50. As is clear, this population was increasing, lengthening health and lifespan. However, mental health is very important and encompasses safety, stigma, and more. She said with her current research, as of yet, she was unable to draw conclusions for her first research question. She would also look more into information on the general population living without HIV and see how it could inform her research for PLWH who are over 50. However, she noted that this may be difficult and not always completely applicable to HIV-positive contexts.

She said that she would like to find more formal research about the RWHAP funding streams, themselves. She would also like to make connections with people who can point her to the proper resources. She said that Target HIV had helpful information but not formal research.

J. Henrikson noted existing EMA services. She said when she was in Michigan, she helped to facilitate an aging program as well.

There was "Positively Aging" in Chicago, Illinois at Test Positive Aware Network. It included a four-week therapy group, social outings and peer support, transportation, and meals. There were comprehensive mental health services and case management integrated with on-site medical care. Additionally, the social activities address social isolation.

The next, "Aging with HIV/AIDS/STIs: The New Senior Challenge" in Fort Lauderdale, Florida, focused on prevention, education, and counseling services for 55+ individuals with hearing loss or who are sexually active to reduce risky behavior.

"AIDS Project Los Angeles's HIV/HEP C Health Promotion Program in Los Angeles, California focused on MSM of all ethnicities over 50 years old and living with HIV. It had community building, life skill support, health education, and discussion groups.

San Francisco, California offered two groups: "UCSF of Medicine's Golden Compass" and the "Silver Project" programs. They both were healthcare programs to meet the needs of PLWH over 50.

"Older Women Embracing Life" in Baltimore, Maryland formed in 2005 for older women living with HIV. It was a welcoming and confidential environment for people to share stories with each other.

D. Gana said that part of AIDS Fund had a section dedicated to seniors 50+. They had an ongoing program that J. Henrikson might be interesting in looking at. P. Gorman suggested J. Henrikson look on the HRSA Target website for their compilation of best practices. J. Henrikson agreed that this was a great resource for existing services. P. Gorman said that they were currently developing new best practices. She added that the models produced by AIDS Education Training Center would be excellent peer-reviewed models to look at for her research as well.

K. Carter said that Jefferson had a great aging program, and J. Liantonio would have helpful resources. K. Carter said that D. Griffith at the Elder Initiative had also done a lot of work around aging, and may be able to offer other information for her to review. He added that there was a PCA plan on aging as well as a State Plan that may be helpful. J. Henrikson said that the plans were great for getting a view into where public health institutions wanted to focus their attention. K. Carter mentioned the legal aspect older adults experience and how she should consider looking into this.

A. Williams said it was true that many of the community-based organizations or even older adults were also inadvertently acting as gate keepers to their client's sexual health resources and services because they did not believe it to be necessary. G. Grannan agreed, saying it was the same with substance use.

—EHE Situational Analysis, Guiding Principles, Pillar Zero—

N. Johns brought up the guiding principles within the EHE plan on the screen. She said that they could table this discussion for a later date, but they could still discuss the direction they wanted to take with this.

She said that CPC and Prevention would review the situational analysis for EHE. The plan was emailed and also available on the website. She noted that the situational analysis was on page 9 of the EHE plan. She suggested the committee take time to look over the whole EHE plan, and particularly the situational analysis to help guide their work moving forward. She reminded them that the EHE plan was just for the Philadelphia county, but it was anticipated that the plan would need to be expanded to the entire EMA with an expanded situational analysis as well.

The thinking is, that as a committee, they could review the situational analysis and add all that they had learned about the update, including the EPI data from K. Brady, literature review from J. Henrikson, the COVID-19 survey, etc. They could review the needs assessment within the situational analysis.

They could also look at potential projects to work on, questions to answer (with the possibility of requesting more information from AACO), more to add into literature review, more needs assessment activities, etc. They could review EHE within HIPC planning and RWHAP responsibilities. She mentioned that there was extensive conversation around mental health and needs of elders today, so she suggested that this could also help to guide them.

The guiding principles, N. Johns said, were similar to those on page 20 of EHE. She suggested everyone take time to look at Pillar Zero. She reviewed Pillar Zero—please refer to the EHE plan for more detail. She wanted to make sure that everyone was familiar of the plan, because this would guide their way forward to activities and strategies for the future. She added that this would be a good partner in looking at the next Integrated Plan. The two plans could inform each other.

M. Ross-Russell added that HRSA and CDC had not yet come out with their new guidance for the Integrated Plan. She said that HRSA and the CDC also had their own EHE guidance/plans. This would be occurring concurrently with the Integrated Plan guidance rollout. It is highly probable that the new Integrated Plan would look like a modified version of EHE plan expanded to the 9 counties. She suggested that the sooner these discussions around EHE and the Integrated Plan happened, the better.

Other Business:

None.

Announcements:

D. Gana announced that Action Wellness would virtually holding its annual Glamcino Royale on February 18, 2021. Tickets were $50, and the money went mostly to the Buddy Program. Typically there is a raffle, including several nights at different hotels throughout the country, wine, gym memberships, etc. You could get the tickets online at the Action Wellness website.

D. Gana announced that Action Wellness was no longer doing HIV testing, because their funding source had ceased. There were two months left in funding source but they lost their tester for those last two months.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the January 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:57 p.m.

Respectfully submitted,

Sofia Moletteri, staff

Handouts distributed at meeting:

- January 2021 CPC Meeting Agenda
- October 2020 CPC Meeting Minutes
- EHE Plan
- Housing Proposal Summary