Meeting Agenda

VIRTUAL:
Thursday, March 18, 2021
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(February 18, 2021)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - Integrated Plan Section 2 Update
    - EHE and Potential Recommendations
    - CPC Co-Chair Nominations
    - Cultural Competency Training
- 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: April 15, 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, February 18, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

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

Guests: Janielle Bryan, Jazzmin Boyd, Debra D'Alessandro, Krista Hein, Blake Rowley, Julia Scarlett, Nicole Swinson, Javontae Williams (AACO)

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

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

Approval of Agenda: G. Grannan referred to the February 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. N. Johns reminded the group that everyone was free to vote in CPC meetings, HIPC member or not. **Motion:** G. Keys motioned, D. Gana seconded to approve the February 2021 CPC agenda. **Motion passed:** 73% in favor, 27% abstaining. The February 2021 CPC agenda was approved.

Approval of Minutes: (*January 21, 2020*) G. Grannan referred to the January 2021 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the January 2021 minutes. D. Gana amended the minutes, explaining that in the "announcement" section, Glamsino was spelled with an "s," not a "c." N. Johns said that all of those in attendance for the last meeting could vote. **Motion**: G. Keys motioned, D. Gana seconded to approve the amended January 21, 2021 meeting minutes. **Motion passed**: 73% in favor, 27% abstaining. The January 2021 CPC minutes were approved.

Report of Chair:

No report.

Report of Staff:

N. Johns reported that this would be her last CPC meeting, and she would be leaving OHP to start a new position in March. She said she would miss HIPC members and OHP staff. They could discuss committee work and timeline to help smooth the transition. In the interim, M. Ross-Russell would support the committee until staff could shift roles. N. Johns explained that she would be with OHP until March 3rd. She would continue her work with HIV with Merck to

help with community engagement and PrEP initiation strategy. This was still a local position, making it easy to keep in touch with HIPC.

N. Johns reported that there was helpful information on the HIVPhilly.org website that S. Moletteri worked on. There was now an "About HIPC" page as well as a "Member Resources" tab. They would continue to remind members and visitors of these resources. She asked that attendees email staff members if they needed assistance.

G. Grannan thanked N. Johns for all of her work and wished her well on her future job placement.

Discussion Items:

—COVID-19 Writeup—

N. Johns presented the COVID-19 survey data. She reminded the group that during the January 2021 meeting, they reviewed the survey results on SurveyMonkey. To consolidate the information, N. Johns crafted a brief, four-page write-up on the results. The write-up contained one table that condensed the information while other information was redacted due to a small pool of respondents.

N. Johns said that she would ensure that the information was available for the committee. G. Grannan asked if N. Johns could highlight any conclusions from the survey. N. Johns said conclusions had to take into consideration that there were limited responses. They could not make generalizations since there was a small pool of respondents. However, with the information they collected, the average income was much higher than those the Ryan White system served. N. Johns said that this was likely because respondents could access and answer the survey online.

She explained that the office was looking into how they could distribute surveys in the future to receive more diverse and representative responses. They could review best practices to follow and work with AACO to investigate their methods of data collection. She mentioned that there were many other ways to collect information, e.g., through AACO and other local and state health departments. They could leverage these resources by tapping into these data sets to help formulate local HIPC needs assessment activities. She considered how it would be more reasonable for OHP/HIPC to facilitate focus groups instead of distributing extensive, virtual surveys.

COVID-19 survey responses indicated that individuals did not have much disruption to their HIV care or adherence to medication. The challenges the survey uncovered included general issues that were not directly related to COVID-19. A longstanding difficulty included housing, involving pre-COVID issues such as the difficulty of staying housed, difficulty paying utilities, etc. New issues that arose due to COVID-19 involved closed offices and hesitancy with transportation. She noted that accessing medication was an issue for a few people, but the cases seemed situational. For example, one respondent's pharmacist ran out of medications for two

months. Unfortunately it was impossible to follow-up with the respondent due to the anonymity of the survey.

Fear, loneliness, social isolation, etc. was a trend among respondents. This would be meaningful to look into, particularly for elders. N. Johns stated that prior to the pandemic, those who were attending 12-step programs reported to continue their programs throughout COVID-19. She noted that CPC had spoken of support groups in the past, outside of the COVID-19 context. Specifically, they focused on psychosocial support.

In summary, N. Johns explained that the committee did not have a concrete way to measure COVID-19's impact on RW clients and PLWH from this survey since the sample did not include respondents with significant financial and housing challenges. This was especially true when considering what would happen with the wrap-up of the eviction moratorium.

K. Carter mentioned the importance of overcoming the digital divide as something to consider, especially with the lack of responses from individuals hard hit by the pandemic.

—Integrated Plan and Situational Analysis—

G. Grannan said that the meeting reminder via email contained links to both the Situational Analysis and Integrated Plan. If anyone had trouble accessing the documents, he recommended that they notify staff within the Zoom chat. S. Moletteri put links to both documents within the chat.

N. Johns said there was not yet CDC/HRSA guidance on the new Integrated Plan, but they would likely receive guidance soon. She noted that processes were slowed due to COVID-19. She explained that OHP, HIPC, and AACO work collaboratively on the Integrated Plan. In the past, the Integrated Plan was broken into two separate plans—a prevention plan and a care plan. However, as of the last plan, the two were combined to create the first Integrated Plan.

She explained that the first section of the EHE plan laid out the HIV epidemic within the EMA. There was a summary of the epidemiological profile, explanation of the workforce, identification of services and gaps in services, dissection of the HIV care and prevention system, identification of barriers, etc.

Section 2, which they would review today, reviewed activities and strategies to achieve goals and objectives. She said that this committee would look at the "care" portion of the second section, while Prevention Committee would look at prevention, e.g., testing and PrEP indicators. However, there would be an overlap between the two committees.

N. Johns said that the responsible party was often AACO of the PDPH. Other responsible parties included PDPH, HIPC, OHP, clinical providers, health care facilities, etc. She also referred to the "acronym cheat sheet" on the HIVPhilly.org website under the "Member Resources" tab for those unfamiliar.

She said that many of the activities in the plan were written at least five years ago. Some activities were updated/added in 2018 due to programming shifts. Other activities, such as PrEP, navigation programs, testing, etc., prompted the 2018 update.

For Goal 1: Reduce new HIV Infections, the activities were written so as not to be too specific with respect to numbers and percentages. The reason for this, N. Johns noted, was because many of the activities were ongoing, and some were new programs, initiatives, or just intentions. Some plans, such as the EHE, had more specificity.

For now, the group would review data indicator outcomes. Some of the data had changed, and they could discuss the change within the group. She explained that any changes in funding, program, policy, etc., were important to keep in mind since they would affect the data. For example, drastic changes in data did not necessarily indicate a good or bad change and could have been due to funding/policy/programs/etc. She added that the 2016 data informed the 2018 update. During this meeting, they would review baseline data from 2019 and check on progress while keeping in mind that not all 2019 data was available at this point.

N. Johns explained that the plan's highlighted portions were spaces in which 2019 data still needed to be entered or edited. Once the plan was updated with the 2019 baseline data, then footnotes could be offered along with explanations as to why data had changed or was not yet available.

N. Johns skipped the first few strategies, as they were prevention-related. She noted the PrEP-related strategy, 1.2.2., noting that Dr. K. Brady recently presented this data to HIPC. She explained that this activity focused on coordinating the provision of PrEP and nPEP. Coordination of PrEP and nPEP was also occurring through the annual National HIV Behavioral Surveillance Data from CDC. This report collected data from different populations each year. The last time data was collected from MSM was in 2017. From this 2017 data, it was revealed that almost 30% of respondents discussed PrEP, compared to data from 2015, which showed that only 5% had discussed PrEP.

N. Johns explained that some of the same data indicators were used to measure multiple activities for ease of data measurement and comparison.

N. Johns read Strategy 1.2.3. of the Integrated Plan, the activities, and the data indicators, including the amount of syringe access sites. Please refer to the Integrated Plan for more information. Notably, the syringe access sites increased from seven in 2016 to eight in 2019. In 2016, there were 2.4 million syringes exchanged, and 2019 data showed 3.9 syringes exchanged.

A new indicator was added, which involved expanding access to MAT for opioid dependency throughout the EMA. This was added in 2018, and data was collected through RW providers. Data showed that in 2019, 52 PLWH received MAT through a RW provider. When reviewing that Substance Use Treatment under the activities column, there was a significant increase for Substance Use Treatment with over 6,000 more units in 2019. She mentioned that HIPC increased spending in Substance Use Treatment over the last two years. M. Ross-Russell added

that she did not know if there was an increase with SAMSA funding, but RW increased the service dollars for Substance Use Treatment as part of the allocations process.

N. Johns next reviewed Strategy 1.2.4: Reduce the amount of HIV within communities. Please refer to the plan for more information. One activity was to support treatment adherence activities. This involved looking into the percentage of eligible medical case management clients who were accessed and counseled for adherence two or more times at least three months apart. She says there was a change from 89.5% of clients in 2016 to 65.6% in 2019. She noted that for the 2019 data, the denominator included any HIV+ clients who received at least 2 MCM services, at least three months apart, and who were prescribed ART.

For strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA, this looked at the Fetal Infant Mortality Review Community Action Team Report. She explained that this would be more of a focus within the Prevention Committee. Please refer to the plan for more information.

N. Johns skipped to Goal 2: Increase access to care and improve health outcomes for people living with HIV. She said that this goal would be a primary focus for CPC. Please refer to the plan for more information on Goal 2.

Strategy 2.1.1 focused on linkage and navigation services. In 2019, she explained an additional data indicator added from the Data to Care program, which offered more information for the 2019 data. There was a reduction of ARTAS clients from 2016 to 2019, but this could be explained through the added data indicators. About half (166) of clients were relinked within 90 days of referral, about half of clients (170) were suppressed within a year of referral, nearly 40% (134) were virally suppressed before referral and remained virally suppressed, and approximately 10% (40) of people were not virally suppressed before referral but became virally suppressed one-year post referral.

N. Johns looked at Strategy 2.1.2. In terms of reducing systemic barriers, she said they wanted to ensure that those tested could have clinical linkage to care. There was a change in co-located testing and clinical sites due to Philadelphia's funding changes for the 2019 data. There were 65 clinical sites also offering HIV testing in 2016 and 24 in 2019 (Philadelphia). Funding and policy were two of the biggest reasons for such changes.

In terms of RW services and Strategy 2.1.3, the goal was to continue centralized MCM intake through AACO's CSU. There was an increase in client intake from 2016 to 2019.

Regarding Object 2.2: Increase the percentage of people with diagnosed HIV infection retained in care. She said that the following strategies followed the same pattern. She reviewed the second activity of Strategy 2.2.1. The data for 2019 indicated that more people were appropriately screened for mental health needs.

N. Johns reviewed Strategy 2.2.3: Reduce systemic barriers to retention in HIV care. The goal was to develop a plan for retention in care, including transportation. She said that the Comprehensive Planning Committee accomplished this activity and worked on a plan for over a year to reduce systemic barriers. This plan was developed in 2018, and informed directives were

sent to AACO. She said that since the committee's work increased retention in care and viral suppression, these activities directly aligned with CPC's work.

N. Johns looked at the second activity under Strategy 2.2.3, noting that in 2016, HIPC talked to the PA Department of Health about cost-sharing assistance for health insurance. M. Ross-Russell believed that PA was still the only state within the United States not to use Part B money for insurance cost-sharing. N. Johns said she would look into this further to see if this was still true.

N. Johns next looked at Objective 2.3: Increase the percentage of people with diagnosed HIV infection who are virally suppressed. The first strategy involved reducing individual barriers to treatment adherence. The first activity under this strategy looked into increasing access to food banks and other food services measured by RW food bank units and PDPH CSU data. There were 80,481 units in 2016 and 78,410 units in 2019. She said that 30% of intake clients reported a need for food assistance in 2019, which was collapsed data and was likely similar to the 2016 data.

She next looked at the second activity under Strategy 2.3.1. regarding the provision of high-quality MCM. This was measured by the percentage of clients who had a service care plan. In 2016, 65.1% of RW MCM clients had a plan compared to 62.1% of RW clients in 2019.

She next reviewed Strategy 2.3.2: Reduce individual barriers to ART. In 2016, 90.6% of RW clients were insured, and in 2019 88.2% had any health insurance. She explained that for 2019 data, the denominator included any client who had insurance status entered. If the denominator was expanded to any client who had a service (including blank insurance values), the outcome became 81.4%. She said that she was still working on SPBP and ADAP information to update data.

N. Johns next reviewed emergency pharmaceutical assistance. M. Ross-Russell explained the difference between LPAP and EFA: Under LPAP, refills were 30 days apart while EFA was on a 14-day prescription. EFA, she noted, included only emergency prescriptions. In contrast, LPAP included a 30-day prescription when clients were waiting to get into the AIDS Drug Assistance Program (ADAP) or did not have another way to access insurance. She continued, noting that LPAP was not for emergency purposes. N. Johns pointed to a change in data indicators for 2019 since the LPAP unit charged from 30-day to 14-day because enrollment into SPBP/ADAP became more efficient. Patient access to medications was not affected. M. Ross-Russell said the money was moved from Local AIDS Pharmaceutical Assistance Program to EFA due to underspending under LPAP. It was reduced both this year and last year. N. Johns added that there were significant improvements to SPBP, so there was a decrease in the need for the service. M. Ross-Russell said that PA and NJ both had all ARTs and other medications included in their formulary. N. Johns noted that if a medication was FDA approved, people could access it.

N. Johns reviewed Objective 2.4: Increase the percentage of PLWH retained in HIV care who are stably housed. She explained that the data indicator units had shifted between 2016 and 2019 since units went from 27,060 Housing assistance units in 2016 to 124 units in 2019. M. Ross-Russell agreed and said that the measurement was different. N. Johns noted that she was still looking into this and needed HOPWA data still.

N. Johns mentioned how CPC discussed housing in-depth, which resulted in their Shallow Rent and Homelessness Prevention proposal. N. Johns next read Strategy 2.4.3. This was measured to look at the percentage of RW MCM clients with current housing status data. The data show that there were 78% of RW MCM clients with current housing status in 2016 and 97.7% in 2019. This was a significant improvement.

N. Johns scrolled to Goal 3: Reduce HIV-related disparities and health inequities. She noted that the first objective was to reduce HIV-related disparities in new diagnoses among high-risk populations. She explained that this goal/objective was prevention-related. It also explored MSM of color and social determinants. The information also contained NHBS data around PrEP. Strategy 3.1.3 addressed social and behavioral health and culturally competent MCM and community-based settings. Under this strategy, it identified that there were 5,999 MCM clients in 2018 and 5,718 in 2019. This data collection was used to measure culturally competent MCM in community-based settings throughout the EMA. She said providers decreased from 2016 to 2019.

They also looked at the access and availability of Substance Use Treatment and Mental Health Treatment. 6% of individuals calling into CSU also needed Substance Use Treatment and 7.7% in 2019. She reported that the number of RW Mental Health clients was in 2016 was 2,137 and 2,068 in 2019. In 2016, there were 223 RW Substance Abuse Treatment Outpatient clients and 272 in 2019. The increase in clients was due to an increase in funding allocated to Substance Use Treatment Outpatient.

D. D'Alessandro asked if there was a standardized CSU intake that included questions about substance use and mental health or if the information was self-reported from clients. N. Johns said CSU had a standardized questionnaire so that such questions may have been included in the questionnaire. D. D'Alessandro suggested this may be underreported data due to stigma. N. Johns agreed, noting that across data, there were often significant disparities. When people call in for medical care, she said, they usually did not pay attention to substance use, mental health, or even dental care until they received medical care first.

M. Ross-Russell said that during the recent intake data presentation, A. McCann-Woods noted there was a significant increase in overspending for Mental Health. K. Carter asked if HIPC had reviewed the CSU form that clients received when they called in. M. Ross-Russell responded that HIPC never reviewed it. K. Carter asked if they could review and discuss the form in the future. M. Ross-Russell said she would ask for it.

N. John reviewed Objective 3.2: Reduce disparities in viral suppression and read the first strategy. To measure quality improvement efforts to address inequities along the care continuum in the RW clinical and MCM services, they reviewed several Quality Improvement Plans or other activities to reduce disparities at provider sites. There was no data for this in 2016, but there were 16 in 2019. The same data was used to ensure clinical and support services addressed unique needs and life experiences of disproportionately affected populations. For supporting a comprehensive and geographically diverse RW care system to provide access to ARVs and treatment adherence services, they measured the percentage of clients virally suppressed. In

2016, there were 84.1% of RW Outpatient Ambulatory Care clients were virally suppressed, and in 2019 there were 87.6%.

N. Johns next reviewed Strategy 3.2.2. about affirming and competent care for transgender women, women of color, MSM of color, PWID, people experiencing homelessness, and those with limited English-proficiency and health literacy. One way to measure activities under this strategy was to look at several medical case managers who attended trauma-informed care and/or cultural competency training in a measurement year through the Case Management Coordination Project. They started recording data in 2017, so there was no data for 2016. In 2019, 54 MCMs attended trauma-informed care trainings, and 129 MCMs attended cultural competency training.

D. D'Alessandro said that, looking back at 2020, the Health Federation noted an increase in training attendance. In response, the Health Federation added more trainings on self-care and trauma-informed care both by staff and clients due to pandemic-related care. She noted that there was a large increase in trained staff.

N. Johns looked at Goal 4: Achieve a more coordinated response to the HIV epidemic. Please refer to the Integrated Plan for the list of strategies and activities. She emphasized Strategy 4.1.3: Continue and expand efforts to make relevant public data accessible, useful, and user-centered. OHP launched their HIV services resource database for public use in 2017 to help achieve activities under the strategy. She asked that people review this resource and note any corrections if needed. As for the activity about informed decision-making, she said that there were ongoing evaluation and feedback efforts from HIPC to OHP to ensure that information was adequately provided and accessible.

N. Johns noted that there was an ongoing collaboration between OHP and PDPH/state planning meetings in PA and NJ through the HIPC participants. She explained that communication between these entities had improved. She also noted that the Planning Council and HPG integrated in 2017, which integrated planning processes. She said that the updated plan data would be available on the website in the near future.

M. Ross-Russell mentioned the release of NHAS. This came out in January 2021 and was available on the OHP website. NHAS contained the same four guiding questions, and that it was fairly consistent with the Integrated Plan. She suggested further reviewing NHAS, which was based on EHE plan language/guidance. Consistent with EHE guidance, NHAS contained goals within the plan, which had an end date of 2030 with interim goals for 2025. CPC/HIPC would likely spend more time reviewing the EHE Situational Analysis. She mentioned that, initially, EHE planning guidance was for 48 counties and seven states. Philadelphia was one of the counties included. Most likely, she said that the Situation Analysis would need to be expanded to include the nine-county EMA.

M. Ross-Russell noted that within the original Integrated Plan, they had a choice to create a singular Integrated Plan or work with the states to do a combined, state-wide coordinated statement of need SESN/Integrated Plan. For the Philadelphia EMA, they cross two states, so the Integrated Plan was a single document, not by the state. She strongly suggested that individuals take the time to review the National EHE Strategy submitted and released by HHS.

Other Business:

—Next Steps—

N. Johns said she wanted to discuss next steps with the group, such as Priority Setting, the Consumer Survey, etc. M. Ross-Russell added that they would be discussing the upcoming Site Visit. During the OHP staff meeting, staff discussed how, historically, the Site Visit process primarily affected CPC and their work.

M. Ross-Russell explained that CPC was set to work on Priority Setting next year. Based on HIPC's workflow and cycle, they do Priority Setting every three years or less. Part of the process would involve looking at the impact on services and setting priorities given the changes associated with COVID-19. Internally, as OHP unpacked the circumstances, it became clear that most changes due to COVID-19 would become evident in next year's needs assessments. Additionally, the funding associated with this year would be out of sync. She explained that the impact and difficulties RW clients were experiencing at the moment might not be the same as next year and post-COVID. OHP staff discussed how Priority Setting would be most beneficial post-COVID. She explained that the timeline in which money would be allocated would not help with RW clients' difficulties and barriers during the pandemic.

M. Ross-Russell said that the Consumer Survey was typically distributed via snail-mail. The last survey OHP distributed—the COVID-19 survey—was distributed via an online survey. The response rate was significantly lower when just offered online. However, mail-out surveys may prove difficult during the pandemic.

Lastly, M. Ross-Russell reported on the upcoming Site Visit. She said that HIPC members had participated in the past and that this time around would likely involve HIPC members and co-chairs. As part of this process, they would need to have an Executive Committee meeting to discuss how to participate.

J. Williams reported that the city was technically closed, so he wanted to ask for suggestions on inviting them to their community meeting. HRSA wanted to continue EHE listening sessions and review implementation within the jurisdiction. In past listening sessions, he felt that individuals were likely left out of the meeting, so he needed suggestions on who to invite and how to reach out to them. He asked everyone to offer suggestions via Zoom chat or send him an email.

D. D'Alessandro asked if HRSA mentioned their target audience for the listening sessions. J. Williams said he did not know, though it was important to have an ongoing conversation with community organizations, providers, and community members. The listening session would be open to everyone, though it may focus more on PLWH and providers/service workers. N. Swinson said that Haven Youth Center. In. was available to join the sessions. K. Carter said he was interested and that he attended the last HRSA Community Session as well.

N. Johns was unclear about CPC's agenda and next steps for March 2021. She asked if there was ongoing work the committee would be interested in, especially since they would not do Priority Setting this year. She noted that the committee typically focused on creating recommendations, ideas, and questions related to HIPC directives to the recipient.

N. Johns said that March 2021 through June 2021 gave CPC time to come up with recommendations. G. Grannan recommended more discussion around training needs. He said that this could be an agenda item for next month. The committee could also review any essential documents associated with their work and discuss them at the next meeting.

M. Ross-Russell said that they were anticipating another virtual allocations process due to the COVID-19 response. During last year's allocation process, OHP provided comprehensive information on the OHP website to support informed participation in the process. For this to happen again, they needed to assess how to augment participation and increase virtual accessibility. Even though allocations was a financial process, it also addressed documented need and concerns within the community. As they discussed trainings, they could also discuss allocations accessibility and trainings they would like to provide.

K. Carter said committee members should look at the three plans (EHE, NHAS, and the Integrated Plan) and ask any questions. G. Grannan agreed and suggested reviewing them before the next meeting to offer suggestions around allocations.

M. Ross-Russell mentioned that attendees could email her, S. Moletteri, or J. Henrikson with any questions.

G. Grannan said they needed to review the different plans and how they would affect HIV funding. They should also look at how they related to previous and current statements of Priority Setting and reconcile their plans for the immediate future.

M. Ross-Russell noted that the other CPC co-chair was no longer a HIPC member. Therefore, they needed to consider how they would proceed. They could discuss this at the next meeting. G. Grannan agreed that another Co-Chair was needed. M. Ross-Russell said that any CPC member interested in the role could email her with any questions related to responsibilities.

B. Rowley asked about AETC cultural competency training. D. D'Alessandro said she did not know if her organization was the only provider. Her organization had two scheduled trainings on cultural competency training, and in the summer of 2020, they added additional sessions due to the unrest Philadelphia and other cities were experiencing. K. Carter asked if HIPC could host a training on cultural competency. G. Grannan said that they could discuss this within the next meeting when they reviewed trainings generally.

D. D'Alessandro asked when reviewing measurement areas how many RW sites had a provider that could assist with MAT. N. Johns said that she should ask AACO, and OHP did not have this data. G. Grannan noted that this was a question worth asking and receiving hard data, though he knew data and processes were in oscillation due to COVID-19.

M. Coleman said that there needed to be more conversation around marginalized groups. G. Grannan agreed, saying that CPC could discuss this further within their training discussion. K. Carter asked if they could explore humility training with Gilead. B. Rowley said that Gilead could support this if CPC decided to take this route.

Announcements:

D. D'Alessandro announced that March 10th would be HIV Women and Girls Awareness Day. CFAR and PDPH were offering a webinar on this date from 8:30-12:30. They would have She would send the flyer to S. Moletteri to distribute. It would be open to all who registered.

G. Grannan announced that March 3rd would be Sex Worker Rights Day. He asked everyone to take the day to think about how they could empower the lives and work of sex workers.

K. Carter and G. Grannan said that they would miss N. Johns and thanked her for her work at the office. N. Johns said people should feel free to reach out to her.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the February 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 4:01 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- February 2021 CPC Meeting Agenda
- January 2021 CPC Meeting Minutes
- EHE Plan
- NHAS

Recommendations Based on Ending the HIV Epidemic Situational Analysis and Pillars 2 & 4 Comprehensive Planning Committee Thursday, March 18, 2021

Expanding Situational Analysis "Needs Assessment" (Page 10) EMA-Wide:

**Refer to Pillar Zero (Page 21) for more information on how to support the following topics.*

Knowing that living in **Poverty** shortens people's lifespan and heightens chance of HIV acquisition, how can HIPC support EHE to assist those experiencing poverty EMA-Wide?	Knowing that **Structural Racism** creates barriers to care, limits access to resources, and negatively impacts health over time, how can HIPC support EHE to fight structural racism EMA-Wide?	Knowing that **Stable Housing** improves health outcomes, how can HIPC support EHE to assist with housing needs EMA-Wide?	Knowing that **Stigma and Discrimination Against the LGBTQIA+ Community** creates barriers to accessing care and experiencing wellness, how can HIPC support EHE to fight stigma against LGBTQIA+ residents EMA-Wide?
Knowing that **Limited English Proficiency** limits ability to access care, how can HIPC support EHE to help foreign language speakers EMA-Wide?	Knowing that **Experiences of Medical Abuse** discourage individuals, especially minority communities, from engagement in HIV care, how can HIPC support EHE to break down medical mistrust EMA-Wide?	Knowing that **Mental Health** impacts PLWH more heavily and results in poorer HIV health outcomes, how can HIPC support EHE to engage individuals in mental health care EMA-Wide?	Knowing that **Substance Use** puts individuals at higher risk for HIV acquisition, how can HIPC support EHE to better substance use treatment programs and promote safe practices EMA-Wide? **Prevention-Heavy Topic*
Knowing that **HIV Stigma** discourages individuals from accessing care, how can HIPC support EHE to provide care that is respectful and appropriate EMA-Wide?	Knowing that **Negative Encounters with Law Enforcement** discourages sex workers and PWID from accessing care, how can HIPC support EHE to engage sex workers and PWID in care EMA-Wide?	Knowing that **Incarceration** increase prevalence of HIV, how can HIPC support EHE to decrease HIV prevalence in incarcerated individuals EMA-Wide? **Prevention-Heavy Topic*	

EHE Pillar 2: Treat

Identified Gaps:

- Immediate ART (within 0-4 days of diagnosis)
- Re-engagement of out-of-care individuals into medical care
- Ongoing retention in HIV medical care
- Increasing durable viral suppression rates
- Increased access to low-threshold HIV medical care

Key Components to Closing Gaps:

- Outpatient Medical Facilities
- Medical Case Management
- Services to Address Social Determinants of Health (EFA, Food Bank, Housing, etc.)
- Data-to-Care (D2C)

Questions to Consider for Recommendation Making/EMA-Wide Allocations:

1. Which of the identified gaps feels most important to CPC's work and why?

2. How could this gap be tackled on an EMA-Wide level?

3. Considering the information from the "Needs Assessment" portion, which populations/issues are important to keep in mind when closing identified gaps? How can gaps be closed in a way that is mindful of these populations/issues?

4. Which RWHAP Core and Support Services can best be used to help close identified gaps EMA-Wide?

EHE Pillar 4: Respond

Identified Gaps:

- Community concerns regarding data security and privacy, and medical mistrust threaten ongoing MHS (Molecular HIV Surveillance) efforts.

Key Components to Closing Gaps:

- MHS and DExIS
- HIV care and treatment providers
- Substance use prevention and care providers
- Community-based testing agencies
- "One-Stop-Shop" medical providers (one location to provide to provide HIV medical care, PrEP, MAT, MCM, etc.)

Questions to Consider for Recommendation Making/EMA-Wide Allocations:

1. Which of the identified gaps feels most important to CPC's work and why?

2. How could this gap be tackled on an EMA-Wide level?

3. Considering the information from the "Needs Assessment" portion, which populations/issues are important to keep in mind when closing identified gaps? How can gaps be closed in a way that is mindful of these populations/issues?

4. Which RWHAP Core and Support Services can best be used to help close identified gaps EMA-Wide?