Meeting Agenda

VIRTUAL:
Thursday, April 15, 2021
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(March 18, 2021)*
- Report of Co-Chairs
- Report of Staff
- Action Items
    - CPC Co-Chair Election
- Discussion Items
    - Integrated Plan Section 2 Update
    - Topics from March 2021 Meeting
- 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: May 20, 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, March 18, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Ebony Boswell, Keith Carter, Debra D'Alessandro, David Gana, Pamela Gorman, Gus Grannan (Co-Chair), Sharee Heaven, Gerry Keys

Guests: Sanzida Anzuman (AACO), Krista Hein, Blake Rowley

Excused: Allison Byrd

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

Call to Order/Introductions: K. Carter offered to chair the meeting. He called the meeting to order at 2:07 p.m. and asked everyone to introduce themselves in the chat with their name, place of representation, and pronouns.

Approval of Agenda: K. Carter referred to the March 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** D. Gana motioned, G. Keys seconded to approve the March 2021 CPC agenda. **Motion passed:** 89% in favor, 11% abstaining. The March 2021 CPC agenda was approved.

Approval of Minutes: (*February 18, 2020*) K. Carter referred to the February 2021 CPC meeting minutes S. Moletteri distributed via email. K. Carter called for a motion to approve the February 2021 minutes. **Motion**: G. Keys motioned, D. Gana seconded to approve the February 18, 2021 meeting minutes. **Motion passed**: 89% in favor, 11% abstaining. The February 2021 CPC minutes were approved.

Report of Chair:

No report.

Report of Staff:

M. Ross-Russell reported that the OHP office was currently under construction, and was helping PHMC to host COVID-19 vaccinations. She was reporting from the office and would have to mute herself periodically due to construction noises.

M. Ross-Russell explained that at last month's meeting, the committee asked if PA was still the only state within the United States to not use Part B money for insurance cost-sharing. She explained that PA funded some premium cost sharing. The total amount dedicated to premium cost-sharing was about $400,000.

The committee also asked whether they could review the CSU intake form to see if they ask about mental health. M. Ross-Russell reviewed CSU documented need at intake. Documented need at intake included mental health which indicated that CSU was prompted to ask about mental health need. Most recently, the intake percentage for mental health services was 27% which was up 18.5% from 2018.

Discussion Items:

—Integrated Plan Section 2 Update—

M. Ross-Russell noted that she had gone through the Integrated Plan to add further updates to 2018 data indicators. She would not review the entire Integrated Plan updated data without separating out Care and Prevention.

She first reviewed the second page—Strategy 1.1.1: Promote adoption of opt-out routine HIV screening in a variety of health care settings—noting that the 2016 baseline data for the first activity was 3 trainings. They had not yet received the 2019 data, but she would resubmit the request.

She next reviewed page 6—*Strategy 1.2.1: Ensure condom access and promote condom use*. He looked at Activity 3, noting that this request had been submitted. AACO believed that the information was collected. This was part of a massive data request, so some data was either missing or delayed. She explained that S. Branca from AACO would likely get the data to her on Monday, March 22nd.

M. Ross-Russell reviewed page 10—*Strategy 1.2.4: Reduce the amount of HIV virus within communities.* A data request for this information was submitted to the Department of Health for PA. She was waiting to hear back from NJ to find out to whom she would send the data request. Currently, she had the cumulative for both states, but it was not broken down by the EMA. She was waiting the broken down data for the 4 NJ counties and 5 PA counties.

She reported that she was still waiting to hear back for *Strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA* data.

M. Ross-Russell next looked at *Strategy 2.1.1: Reduce individual and programmatic barriers to care*, Activity 2. She explained that the full information for this activity had not yet been filled in. However, the support services allocations for 2019 was 16.5% with final spending being 17.26%.

For Strategy 2.2.1: Activities 1, she still needed to submit the request for the data. For Activity 3, there were 107 ARTAS clients linked which wound up equaling 87.6% virally suppressed clients in 2019.

M. Ross-Russell reviewed Strategy 2.2.2: *Reduce programmatic and provider barriers to retention in HIV care.* All data indicators under this strategy were not yet updated, so she would resubmit the request and hopefully have the data by next time.

On page 23, *Strategy 2.3.3: Reduce systemic barriers in ART*, she explained that the information had been submitted. NJ would be carried over the same way it was before. She needed to get more detail from the Department of Public Health, because when she looked at the data, there were 2,000 clients still outstanding, so she needed to investigate this further.

For *Strategy 3.1.2: Increase access to biomedical prevention interventions*, Activity 4, the data was needed from the AETC data request. She would resubmit a request.

She next looked at *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*. Under Activity 2, she had a response from PDPH for 2019 data indicator updates. She reported that she had information for technical assistance care training provided by AACO, but she did not have the information for training provided by AETC.

Strategy 3.2.3: Increase access to clinical, pharmaceutical, and other services that address co-morbid conditions, including but not limited to viral hepatitis and STIs, Activity 1, she reported that she was still waiting to hear back about ADDP and SPBP from both NJ and PA counties.

For *Strategy 4.1.2: Continue outreach and education to clinical providers outside the RW system*, she explained that this data indicator would be included in the AETC request she resubmitted.

Once all the information was collected, M. Ross-Russell clarified, there would likely still be data that was unable to be updated, no longer being collected, etc. In these circumstance, OHP would add footnotes to incomplete data to explain why it was unaccounted for. Once all data available data was updated, she would work on finalizing the rest of the document to complete it by the summer of 2021.

—EHE—

M. Ross-Russell noted that S. Moletteri put together this worksheet, and they would pick up where other guidance would leave off. S. Moletteri said that this was worksheet was based on the EHE Situational Analysis. It emphasized the care components of the Situational Analysis. However, like the rest of the EHE plan, the Situational Analysis only addressed Philadelphia County and it needed to be expanded to work throughout the entire EMA. She explained that expansion of the EHE plan throughout the EMA would likely be a big part of the Integrated Plan's work. She noted that the next Integrated Plan would be due in December 2022. M. Ross-Russell added that the guidance for the plan would come out either this summer or fall and would pick up where the other guidance left off. She said that they would be looking at a combination of NHAS and EHE. NHAS, she noted, has similar language to the EHE plan.

S. Moletteri said that the worksheet was essentially a summary of the EHE Situational Analysis, with an emphasis on populations and issues that were touched on within the Situational Analysis's Needs Assessment portion. She noted that there were two boxes containing asterisks

within the worksheet, connoting prevention-heavy topics that may not be beneficial for CPC to focus on. She asked that everyone take a second to look at them and identify and expand upon which boxes were most important to CPC's work for care services across the EMA, not just Philadelphia.

D. Gana said that one of the boxes dealt with poverty, which he felt was more prevention-related. K. Carter said that while he was reviewing the worksheet, he felt mental health and stable housing were important topics to CPC and helped people engage in medical care and maintain better health outcomes. D. Gana agreed.

D. D'Alessandro agreed that housing and mental health were primary, though she said it was hard to rank the topics. She noted that supporting incarcerated individuals was also important. D. D'Alessandro asked to rephrase the worksheet box around mental health, noting that instead of focusing on engaging individuals, they focus on building resources. She explained that the issue was not always around engaging individuals in mental health care and that, more often, it had to do with a lack of resources. Patients could have six month waiting periods, so they should consider rephrasing to correctly identify the barrier. P. Gorman agreed, noting that statement appeared to put onus on the patient instead of the mental health care agencies who needed to address their barriers when linking patients to care.

M. Ross-Russell revisited K. Carter's statement, noting that part of the barrier around receiving mental health care involved licensures. Those who were working in that field needed to be licensed individuals, as this was also part of the onboarding process. Requirement of licensures depended on who was contracting with the agency in question. The Ryan White system, she explained, required licensed providers.

K. Carter asked if mental health providers had to work for a providers that were RW funded or if patients could be referred out to approved providers. M. Ross-Russell responded that there was a difference between someone trying to obtain services through a medical provider that takes their insurance and someone working with a mental health provider contracted under RW. There was some control over RW funded providers, but they still had to follow HRSA contracting which included the licensure requirements. Overall, this depended on somebody's insurance and a primary care physician's ability to refer them to another RW provider.

D. D'Alessandro said that the payment system for health insurance for behavioral and physical health services where generally siloed. This was especially the care for those receiving Medicaid in Philadelphia. She mentioned that CBH was the behavioral health carveout for Medicaid recipients in Philadelphia. The Health Commissioner in Philadelphia had regular meetings with all Medicaid management, so she suggested asking AACO to ask health commissioner about better integration. The Division of Behavioral Health and Intellectual Disability now had greater initiative to push for integration between behavioral and physical health services. She asked if HIPC could help with policy advocacy. The more they un-silo behavioral and mental health services and push for colocation, the more accessible behavioral health services would be.

G. Grannan said that HIPC was about to give instructions to the grantee and make funding decisions. Around mental health services, he felt that HIPC needed to emphasize interventions supported by research and data. If they were going to offer instructions, they should follow the practice of having research and data to support their decisions.

D. D'Alessandro noted that Dr. K. Brady was the acting AACO director, so they could broach the physical and behavioral health integration to Health Commissioner T. Farley. S. Anzuman said she could take the message to Dr. K. Brady about advocating for policy changes.

G. Grannan said that addressing housing would bring up many other issues and gaps that the committee had mentioned. G. Grannan said he was hesitant to commit health funding to improve health to support housing. The reason being, he felt that there were other funding streams that could support housing in a more impactful way. He said that this did not mean they did not have to support housing at all, this was just something to consider, given the constraints and limitations that come with RW funding. He noted that there were local capacity issues regarding housing. He also mentioned that the city was starting to remove homeless individuals from areas, similar to how they cleared out the area surrounding the Convention Center. This was done with a lack of support for the people being removed. K. Carter noted that they did not know how many people were homeless and also living with HIV. He added that during the last allocations process, HIPC chose to put in additional dollars to housing services, specifically EFA-Housing.

D. D'Alessandro suggested that when they discuss EHE dollars, they have a larger framework that includes prevention and care of HIV, whereas RW funds only concern the care portion. D. D'Alessandro noted that EHE contained ideas for ending the HIV epidemic that were more "outside of the box." If EHE was able to prove that Housing First leads people being able to access mental health services and other behavioral health services, therefore preventing the acquisition of HIV, this could lead to such programs being funded through other sources as well.

M. Ross-Russell said that EHE was funded by CDC with care and prevention components. These two components were combined to ensure an integrative and encompassing approach. Therefore, she agreed that EHE was much more flexible in what its abilities than RW. In the past, she noted that CPC focused heavily on housing, especially within Philadelphia and how they could help with RW funds while keeping HOPWA in mind.

M. Ross-Russell added that AACO looked at the consequences of COVID-19 and decided to support a shallow rent program to prevent homelessness. They created ways in which they could support people who did not have an income. AACO was still unsure as to why individuals did not apply to the shallow rent program. She said that they can continue to look at housing, noting that it is being tackled from many different angles. HIPC still did not know the restrictions they would have placed on them moving forward. She said that the EHE plan was now in its implementation phase, which is why OHP was presenting the Situational Analysis. The Situational Analysis was specific to Philadelphia, but there would be substantial overlap between plans in the future, and EHE may be helpful. Since NHAS contained similar language and goals to EHE, it was likely that the Integrated Plan guidance would encourage the expansion of EHE.

S. Moletteri said that there was talk of hesitation around putting funding into housing or other services and how they could be supported with RW dollars. However, this discussion around these topics could be innovative, leading to recommendations or directives, which would not be as restrictive as funding decisions.

K. Carter asked if they were looking at giving instructions to the grantee, for example, asking AACO to look at the cumbersome onboarding process for mental health providers. S. Moletteri said, yes, they could also ask for more information. K. Carter suggested that this would be helpful, as they could receive the information needed to tackle the barriers.

K. Carter said that, in the past, D. Gana suggested investigating covered housing which was about $2,500 per unit. People would have doors, a place for their belongings, a bed, etc. This could be "longer term short term" before people felt comfortable moving into permanent housing. He suggested that they look into vacant spaces, such as vacant schools or parking lots that could be transformed into such spaces.

G. Grannan agreed that this was a valid approach. However, due to the COVID-19 pandemic, shelters were not a perfect option, especially for those with health conditions. He suggested that people were living outdoors because their only other option was congregate housing. Congregate housing was not a safe option for staff or those being housed.

D. Gana asked if there was a vacant hotel within the EMA or other such vacant spaces. He explained that other states had housed homeless individuals in vacant spaces. G. Grannan said that they would need to get "buy-in" from the city for such a process to occur. He knew of tiny houses which built to reduce homelessness. He felt that this was a great approach, especially considering the current circumstances.

M. Ross-Russell noted that the committee mentioned a few initiatives that were construction-based—even if semi-permanent—that could not utilize RW funding. She explained that various programs around housing were funded with a combination of general funds through various city municipalities, states, etc. While they could form recommendations around such initiatives, some suggestions may not be under the RW purview.

K. Carter asked to step away from the housing discussion and look more closely at immediate ART. He asked if immediate ART would include immediate prescriptions for PrEP. M. Ross-Russell responded that immediate ART was part of the care component, while PrEP distribution was part of the prevention component, specifically EHE pillar 3. K. Carter suggested they ask for immediate ART therapy.

S. Moletteri mentioned that their earlier discussion barely broached the topic of mental health, as they mostly spoke of it in terms of housing. She asked if they wanted to explore this further. G. Grannan said that stable housing and mental health issues were important to talk about in conjunction, though it would be important flush the topic of mental health services out. When discussing mental health services within the city, structurally, this was often grouped with substance use treatment. In his personal opinion, he said that whether or not people access mental health services, this was secondary to receiving MAT. This was because research that

showed that outcomes with and without counseling around methadone and buprenorphine did not differ in any significant way. He felt that they should acknowledge substance use treatment as well if they were to discuss mental health. This was because most places had joint substance use and mental health care services since they were grouped together under DBH—now DBHIDS—or the Department of Behavioral Health and Intellectual Disability Services.

G. Grannan said that, often, it was obligatory that people receive mental health services if they were to receive MAT. However, he felt it completely valid for people to receive MAT without having to access mental health services. They could decide to investigate this if it proved to be a barrier to MAT and substance use treatment. Additionally, this could potentially address the personnel issue for mental health providers. They could see to what extent people needed to be fully certified rather.

K. Carter asked if G. Grannan was suggesting that they have people trained in a more specialized manner for substance use treatment. G. Grannan explained that one of the barriers to hiring personnel was that workers needed a certain number of contact hours with supervision. He was asking whether workers who were working toward their licensure could assist with substance use treatment. M. Ross-Russell said she believed that the requirement was that workers be licensed mental health providers.

M. Ross-Russell reminded the committee that what was proposed within the EHE Situational Analysis was currently in the implementation phase for Philadelphia. They were looking to expand this throughout the EMA.

K. Carter said that one of the barriers on the identified gap list was getting ASOs to have extended hours. He felt that this was important to review for breaking down barriers to accessing care. M. Ross-Russell agreed that this was an identified gap and that it would be in their purview to form a recommendation around this barrier. K. Carter noted that some places were administering vaccines for 24 hours straight. There were many individuals in need of the vaccine, so hours and accessibility was important and addressed. D. D'Alessandro listed the following barriers to accessing both physical and mental health care: provider hours, child care, transportation.

M. Ross-Russell noted that AACO was looking more closely at a client-centered approach, and the Situational Analysis reflected this. G. Grannan suggested they ask people who are accessing services which supports they needed to overcome certain gaps in services. He said that Philadelphia had no providers open after 5 p.m., saying this would be important to address. G. Grannan agreed with D. D'Alessandro, saying that child care also needed more emphasis and discussion.

K. Carter said that once clients were able to go in-person, flexible provider hours would be important. He also mentioned the digital divide as a current issue for accessing services. G. Grannan mentioned that his organization fundraised to give people phones so they could engage in telehealth among other things. He felt that when people had phones, their lives were able to change very quickly. G. Grannan said that they could address the digital divide by looking into

getting people phones, computers, tablets, etc. as a way to give them a tool to use for closing gaps to care, themselves.

P. Gorman disclosed that she worked at Cooper. She said that—at the beginning of 2020 prior to the COVID-19 response—Cooper surveyed 100 consumers to find out barriers to care. Cooper presumed that the main barrier would be insurance, but the responses were as follows: (1) availability of hours, (2) transportation, and (3) childcare. Childcare, although ranking, was not as high of a concern for respondents as the first two. She explained that this was an AACO-driven initiative due to disparity data.

Additionally, P. Gorman said that Cooper received COVID-19 money from the federal government and that they used this money to purchase smartphones and data plans. The patients who received the devices were happy, but many patients did not know how to use them. Therefore, they had add a digital literacy component into their program. Many times, the issue with telehealth might be the service. For example, someone may be in a telehealth video session and then lose the video component of the call. She suggested that providers give consideration to the education portion of the digital divide for both clients and providers, themselves.

D. D'Alessandro mentioned that Dr. K. Brady was funded to perform the MMP. She asked about the extent to which HIPC could participate in the development of this project and its questions. G. Grannan said that HIPC could access the reports delivered. They had an opportunity to offer input and add local questions, but Dr. K. Brady would have final say. However, the council had a rapport with Dr. K. Brady. Though they could not directly add questions to the survey, they could offer their input. K. Carter said he now attended MMP meetings, so he could report back to CPC about their ability to offer input.

M. Ross-Russell said that Dr. K. Brady usually presents to HIPC—as she did last January—and includes MMP and NHBS data (NHBS was done in cycles by population). In the past, the Council had reviewed the MMP questions. She noted that the survey was extremely lengthy and that the council typically received results from both MMP and NHBS. As they look at the EPI-profile, they look at the data from these two projects as well. For NHBS, M. Ross-Russell said it was possible that the Council could add local questions, but she was not sure if this was also the case for MMP. She explained that MMP surveyed those in care and asked about service needs. NHBS was more prevention-driven and asked questions related to health, access, and risk behaviors. HIPC requests the data and was also free to ask for more if needed. S. Anzuman shared her email and said that she would talk to Dr. K. Brady about both MMP and NHBS.

M. Ross-Russell mentioned how AACO was working on a document to provide to clients to help close the information gap about service availability and other unknowns.

G. Grannan asked if CPC had properly identified a gap most important to their work and why. From his perspective, he felt that stable housing was important to CPC's work and brought in other elements of gaps in care. S. Heaven agreed that housing was important and that this would help with care. She said they should look into how they could support stable housing EMA-Wide. G. Grannan agreed. He added that stable housing would be a tool to close other gaps or

fight other issues. For example, it would not directly help combat racism or assist with substance use treatment, but it could still support people around these issues.

M. Ross-Russell recapped some of the topics CPC had mentioned: extended hours, stable housing, transportation, childcare and access to mental health. Everyone agreed that these were the main topics of interest.

—Co-Chair—

M. Ross-Russell offered additional background around the co-chair discussion, explained that the committees could regulate their own co-chair nomination and selection. Generally, co-chairs were people who participated on a regular basis and had been a part of the Planning Body for approximately a year. However, CPC did not have to abide by these prerequisites exactly. The purpose of two co-chairs would be so if one was absent, the other co-chair could run the meeting. They could nominate people over the next, 30-day period. Then, they would be able to elect the co-chair in the next, April 2021 meeting.

D. Gana mentioned that the position was a two-year term. D. Gana asked if D. D'Alessandro was interested in the position. D. D'Alessandro declined since she was still a new member.

M. Ross-Russell said that nominations for the position could be submitted to her, S, Moletteri, or J. Henrikson. G. Grannan said they could communicate with staff about nominations and vote during the next meeting. G. Grannan said that they could look at past CPC minutes to observe consistent members.

—Cultural Competency Training—

S. Moletteri said that they would likely not have enough time for this discussion item. Last month, the committee discussed cultural competency training, mentioning training from Gilead and how they could incorporate this into HIPC's work.

K. Carter reported that yesterday, he attended a cultural competency training hosted by Gilead. D. Gana explained that it was a webinar on cultural competency and cultural humility. B. Rowley said that there are two parallel types of opportunities from Gilead: (1) a webinar about cultural humility, and (2) actual trainings with staff that would be more interactive and training. The latter, he noted, was more intensive and interactive, designed to outline why the practice of cultural humility at agencies bettered health outcomes for PLWH.

G. Grannan suggested that it would be worthwhile, as a committee, to bring a proposal to the larger council about the training. K. Carter suggested they investigate trainings for staff to suggest to agencies and talk to HIPC about how they wanted to train. K. Carter said it would be helpful for everyone to attend such trainings, since people typically did not realize the amount and weight of biases they carried.

D. D'Alessandro said that she was very impressed with E. Thornburg. She looked into E. Thornburg and discovered that she had a background in cultural humility training. She said E.

Thornburg would be a great "in-house" resource to look to. G. Grannan said that this was a great idea. Additionally, D. D'Alessandro asked if E. Thornburg—or government co-chairs in general—could be subcommittee co-chairs. D. Gana said that HIPC did not typically have AACO as co-chairs on the subcommittees.

G. Grannan asked about AACO's ability to stand in as a subcommittee co-chair. M. Ross-Russell responded that AACO staff participated in subcommittee meetings to provide information on the various subjects at hand. All subcommittees besides Poz Committee had staff from AACO participating. She said she would have to check the bylaws, because there may be issue with HIPC co-chairs acting as subcommittee co-chairs.

K. Carter suggested they ask E. Thornburg to present on cultural competency and cultural humility in HIPC. G. Grannan asked if this would be used as a tool to improve HIPC functions or if it would be geared towards providers. K. Carter said it could be for both. They could also look into required, online trainings. He said that these trainings were part of an ongoing process of improving yourself and your customer service.

B. Rowley mentioned that the Gilead trainings were part of a four part larger series. When discussing cultural competency and humility. G. Grannan asked if the trainings from Gilead would be able to be presented at a council meeting. B. Rowley said Gilead had the ability to train places on a local level, so they could do this. He noted that the trainings encompassed everything around power and privilege, racism, sexism, etc. G. Grannan asked if they wanted to bring a proposal to the council, and K. Carter suggested that they wait until the next meeting.

Other Business:

S. Moletteri said that the Ad-Hoc Recruitment Workgroup was still in the works. She would be sending out an email to gauge who was interested in participating within the workgroup. This would likely be sent out tomorrow. She asked that those who were interested in joining either email her or type in the Zoom chat box. K. Carter asked S. Moletteri to give an overview of the Ad-Hoc Recruitment Workgroup. S. Moletteri said that the Recruitment Workgroup would be working until September. They would likely receive input from Poz Committee and from HIPC members attending the national Recruitment and Retention Learning Collaborative from Planning CHATT.

The Ad-Hoc Recruitment Workgroup still needed to discuss internally what direction they would like to go in. However, it was presumed that they would come up with a recruitment plan to work on recruiting those who were needed most on the council properly reflect the HIV epidemic. K. Carter, said that they should have a plan finalized by September 2021.

Announcements:

D. D'Alessandro announced that the Health Federation of Philadelphia had trainings for primary care providers around opioid use training. They had waiver trainings for prescribing buprenorphine and preceptorships for those who had their waivers but wanted more information. They also just received funding to do a health sequelae of polysubstance use. They had another

training in April about a recent substance being used that was an animal tranquilizer. This training invited a veterinary toxicologist and ER providers to discuss more around the issue.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the March 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 4:07 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- March 2021 CPC Meeting Agenda
- February 2021 CPC Meeting Minutes
- EHE Recommendation Worksheet
- EHE Plan

Topics from the March 2021 CPC Meeting
for the April 15, 2021
Comprehensive Planning Committee Meeting

Directions: *The purpose of this handout is to explore the topics/gaps in care brought up in the March 2021 CPC meeting. Please use the following handout to help explore solutions to close gaps in care. Solutions for closing gaps in care can be addressed by CPC in whatever way feels most effective, e.g. recommendations, policy advocacy, etc.*

Topics Discussed that Involved Possible Recommendations:

- Extended provider hours for accessing care
- Immediate ART

Topics Discussed that Involved Possible Policy Advocacy:

- The integration of Behavioral Health and Primary Medical Care
    - Similar to the "One-Stop-Shop Model"

Topics Discussed that Involved Request for More Information:

- Request for more information around licensure and the onboarding process for Mental Health providers
- Request for more information around whether receiving mental health services is mandated for MAT (Medication-Assisted Treatment)

Other Topics Discussed:

- Child care
- Stable housing
- Transportation