VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, June 10, 2021
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Elise Borgese, Mike Cappuccilli, Keith Carter, Debra D'Alessandro, Lupe Diaz, Alan Edelstein, David Gana, Gus Grannan, Sharee Heaven, Gerry Keys, Kate King, Kailah King-Collins, Nhakia Outland, Erica Rand, Samuel Romero, Clint Steib, Desiree Surplus, Nicole Swinson, Evan Thornburg, Adam Williams

Guests: Anna Thomas-Ferraioli (AACO), Ameeah McCann-Woods (AACO), Kevin Moore, Blake Rowley, Mike Valentin

Excused: Allison Byrd, Marilyn Martinez

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

Call to Order: L. Diaz called the meeting to order at 2:05 p.m.

Introductions: L. Diaz asked everyone to introduce themselves within the Zoom Chat box: name, area of representation, and what you are looking forward to with the reopening of businesses.

Approval of Agenda:

L. Diaz referred to the June 2021 HIPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, G. Grannan seconded to approve the June 2021 Planning Council agenda. **Motion passed:** 83% in favor, 17% abstaining. The June 2021 agenda was approved.

Approval of Minutes (*May 08, 2021*):

L. Diaz referred to the May 2021 HIPC minutes S. Moletteri distributed via email. L. Diaz asked for a motion to approve the May 2021 minutes. C. Steib mentioned page 8 of the minutes, noting that it stated the Positive Committee "did" have an official vote to change their name to "Poz Committee." He was under the impression that they "did not." S. Moletteri agreed that they did not have an official vote and would correct this within the minutes. **Motion:** G. Keys motioned, D. Gana seconded to approve the amended May 2021 meeting minutes via a Zoom poll. **Motion passed:** 72% in favor, 23% abstaining. The May 2021 minutes were approved.

Report of Co-Chairs:

E. Thornburg yielded her report time to A. Thomas-Ferraioli. A. Thomas-Ferraioli introduced herself as the EHE Advisor at AACO. She explained that this summer, AACO would be

launching a Philadelphia EHE Collaborative. The collaborative would be a working group with the intention of bringing together stakeholders to engage in shared learning for both best practices and information around EHE efforts. It would consist of an Internal Steering Committee, an Executive Committee (with leaders in all three regions), and workgroups (both topic-specific and time limited). Once the meetings were scheduled, she would share the invitations for each of the various workgroups and what each were needed regarding attendees/representation/expertise.

K. Carter asked if they were also participating in the Penn ISPHERE (Implementation Science in Philadelphia for Ending the HIV Epidemic REgionally) Efforts. A. Thomas-Ferraioli said that they were but that they were separate entities.

Report of Staff:

M. Ross-Russell reported that the allocations process would likely take place in July. They would likely follow the same process as the previous year. They had hosted three meetings over a three-week period for each region. Each region took up a week and had a Tuesday, Wednesday, and Thursday meeting. Last year, there was no July HIPC meeting because of the time-consuming allocations process. OHP staff, she noted, would be available to answer questions on Wednesday from the Tuesday meeting and in preparation for the Thursday meeting. This would all occur virtually. The materials would be updated and made available as soon as they were completed.

She also reported that from the Site Visit, there were two citings. As a result, they would have to meet with the Executive Committee about a form for Monitoring the Administrative Mechanism for Rapid Distribution of Funds. S. Moletteri would set up a Doodle poll for the Executive Committee to pin down a meeting date.

M. Ross-Russell reported that City workers were returning to the offices, effective July 6, 2021. OHP would return on July 6th, and she would keep everyone posted. L. Diaz asked if they would transition into a hybrid plan for council and committee meetings. M. Ross-Russell said this would be part of their Executive Committee discussion but that the hybrid structure was likely how they would proceed. She said that some individuals had not received a COVID-19 shot, so there was still a mask mandate.

J. Williams said that a couple of groups he participated in found the hybrid model to be effective. While there were technical and access challenges, Zoom still saw increased participation. Zoom offered flexibility when it was harder for people to commute and attend in person. L. Diaz said some meetings were back-to-back, so hybrid would be important when attending back-to-back meetings in person were impossible. D. D'Alessandro agreed that expanded access to meetings was the most notable advantage. She said her organization was also looking into a hybrid model for trainings. The most significant challenge of a hybrid model, however, was consideration of mics, cameras, etc.

S. Heaven mentioned that not all offices were going back 5 days per week. Some city offices allowed employees to work up to 3 days from home. For those who do not work directly with

clients every day, they could consider also adopting the hybrid model as an office. K. Carter said that those having issues with digital divide could be offered "first dibs" for coming in person. Those who had the digital accessibility could continue meeting from home. L. Diaz agreed. G. Grannan agreed and highlighted how this would give them a chance to talk to those who had trouble with remote meetings. While in person, they/OHP could ask participants what kind of support they needed to meeting digitally or at all during COVID-19, if hybrid was a useful model, etc.

L. Diaz asked that when the Executive Committee met, OHP could provide these minutes with K. Carter's and G. Grannan's comments to assist with their discussion. S. Moletteri said they could.

Public Comment:

None.

Presentation:

—Mental Health and Addiction Treatment for PLWHA—

K. Moore introduced himself as the Executive Director of Courage Medicine, a new nonprofit. They had a location in Northeast Philadelphia and would soon have one in Southwest Philadelphia as well. They provided comprehensive primary care, HIV specialty care, psychotherapy, opiate use disorder, STI testing, etc. He mentioned Dr. T. Acri who was their Medical Director and would try to make the meeting today to co-present with him. He said he would discuss the current mental health addictions treatment for PLWHA.

K. Moore said that M. Ross-Russell asked Dr. T. Acri and him to offer a clinical update for PLWHA. He would offer a presentation on both mental health and addictions since they were overlapping.

He noted that some of these slides were from another presentation. He notified everyone that he had worked at Widener as well for the past 9 years. He said he would mention brand names such as Suboxone, but he had no affiliation with any pharmaceutical manufacturer or company.

He flipped to the next slide and asked the following question: What percentage of PLWHA are depressed and/or anxious? Within the Zoom chat, most people answered more than 80% and others answered between 60%-80%.

He addressed the next slide. Though everyone had answered high percentages for the last question, the actual percentage for diagnosis was relatively low at 20-40% of PLWH for Depression and about 16% for Anxiety. Personally, he doubted these findings, and he would later address the discrepancy. At the other clinics he worked at, because he doubted the findings, he also performed research and found that numbers were relatively similar with about 50% at one clinic and 55% at another screening positive for Depression. N. Outland asked if individuals were misdiagnosed, and K. Moore answered that it was likely underdiagnosed because

individuals might not realize they were dealing with Depression or were hesitant to talk to a mental health provider.

He addressed the question on the next slide: What percentage of PLWHA have a history of addiction. Most people guessed 75% or below. K. Moore said that the percentage of people in need of Substance Use treatment was about 24%. However, when he screened at two clinics, the results were about 80% at one clinic and 75% at another. This discrepancy between substance use disorder and mental health disorders, he felt, could be explained since people were often more honest about substance usage than personal mental health issues. Additionally, the initial underreporting in CDC numbers for Substance Use amongst PLWH was likely due to hesitancy and lack of trust because of the War on Drugs. The criminalization of Substance Use might deter people from seeking out the Substance Use treatment they need. There was distrust in medical care, Substance Use care, and even less trust in mental health care. D. D'Alessandro said this was not just an issue of trust either--there was also limited availability of behavioral health care. K. Moore agreed that there was not enough access; there were waiting lists to receive services along with vacancies in agencies for mental health and Substance Use.

K. Carter asked if the questions he asked when screening at his two clinics were different from the CDC questions. K. Moore said he repeated the methodology and that everything was the same. He suggested that this indicated a far larger issue. G. Grannan asked if the surveys distinguished between "use" and "abuse." K. Moore responded that this was a limitation, because the language the CDC used was unfortunately outdated and used "abuse." As mentioned, they wanted to keep the language the same.

Regarding the slide titled "Main three mental illnesses (+)," K. Moore was speaking on Depression and Anxiety/trauma. He explained that Depression was time-limited and would generally go away on its own. The human mind could adapt to diverse circumstances. Some people, of course, were unable to adapt fully. He said that those with chronic Depression would need treatment to assist with shortening the amount of time they would suffer with Depression. Anxiety, however, was long-term and people continued to suffer without treatment. Substance use was included as a mental illness, because it was intrinsically related. Once addiction was acquired, it was chronic. The opioid epidemic, which now included the spike in use of methamphetamines, was fatal. There was a great demand for treatment.

N. Outland asked if K. Moore could speak on the difference between mental health and mental illness. She said the title stated mental health as opposed to mental illness. He responded that they could be used interchangeably but that mental health was preferable.

K. Moore reviewed the bottom of the slide "Main three mental illnesses (+)" that listed psychotic disorders. Psychotic disorders, like Schizophrenia and Bipolar, meant reality testing in a patient was impaired, leading to hallucinations and delusions. Though they were rare, it was important to discuss them. K. Carter noted that POC were diagnosed at a much higher rate with Schizophrenia. K. Moore agreed that this was true. He explained that, with Schizophrenia, it was often underdiagnosed. Seeing increased diagnoses would be good except for the fact that people who were temporarily psychotic due to substance use were sometimes misdiagnosed with

Schizophrenia. He added that this misdiagnosis of addiction as Schizophrenia could also account for the underreporting of substance use disorder.

L. Diaz asked how often mental health conditions were confused with substance use. K. Moore said that stimulants, particularly, could look similar to Schizophrenia. This misdiagnosis of addiction for a psychotic disorder was very common. Clinicians could only form a proper diagnosis after a month or more of the patient not using substances.

N. Outland returned to her comment about the difference between mental health and mental illness. She said that mental illness could make it difficult for an individual to function over large periods of time whereas mental health could be used positively or negatively--it was a more neutral term. K. Moore thanked N. Outland for the clarification. D. D'Alessandro thanked N. Outland for the comment, emphasizing that this highlighted the importance of "person first language" so they did not equate people with their mental health/illness diagnosis. B. Rowley agreed, saying that he thought of "mental health" as a spectrum and "mental illness" as the diagnosis. K. Moore agreed that mental illness referred to diagnosis.

K. Moore continued to the slide titled "HIV interacts with mental illness." Biologically, he said that the virus itself could cause Depression due to viral inflammation of the brain. Additionally, he felt that worrying about health, CD4 count, and stigma could also contribute to Depression. Lastly, he said that Substance Use increased the likelihood of HIV transmission. This was important to keep in mind going forward.

After having discussed mental health, illness, and addiction, K. Moore now wanted to discuss treatment. Harm reduction, he said, was the evidence-based approach for helping individuals with addiction. Abstinence, he pointed out, may be some people's goal, but it was not most people's goal. The majority of individuals wanted to reduce and control their substance use as a goal. The point of harm reduction was to reduce harmful substance use so individuals could have more control over their lives. Such a goal could mean only reduction. At this point, abstinence-only models were against science.

K. Moore offered an example of a common scenario of harm reduction with the made-up patient, "Bessie." Bessie said she needed help with her heroin use, but she wanted to continue marijuana use and alcohol consumption. K. Moore said that this was safe and followed harm-reduction protocol. Alcohol, being a sedative, called for a reduction in consumption when also using MATs such as Suboxone and Buprenorphine. Bessie, after the start of treatment, reported back and said she was feeling her emotions in a present way, and this helped her increase motivation to continue HIV medications and adhere to treatment.

Within this scenario, three months later after treatment, Bessie found herself unable to get out of bed, restless, not hungry, and suicidal. Though she got control of her heroin and alcohol addictions, she found herself facing symptoms of depression. He explained that Bessie had a lot of traumas that had not been properly addressed. With the increased awareness of her emotion, she quickly realized she was unhappy with where she was in life. Therefore, they asked Bessie to visit the clinic twice a week and to start taking antidepressants. She initially felt much better.

Six months later, Bessie developed a flood of memories. Specifically, she recalled getting stabbed: she started to become fearful of leaving her apartment, she was having panic attacks, suffering from nightmares, and generally was feeling anxious. K. Moore noted that her memories, emotions, and trauma were catching up to her. Therefore, they got her treatment to cope with this while also working on Anxiety management. Bessie performed breath training for panic attacks, muscle tension training, and reworking thoughts to clarify her current circumstances versus her past circumstances. They discussed ways to work this through the trauma so she felt less affected by in in her daily life.

After facing her opioid addiction, Depression, and Anxiety, she worked really hard and eventually got better. A year later, Bessie felt like herself. She had acquired skills she could use long-term, and she could continue to reach out to people for assistance if needed. He said she had been given timely access to treatment which is why she saw success in treatment. If she had allowed her Depression to continue untreated, successful results would have been much more difficult for her. Ultimately, Bessie had increased motivation to adhere to her HIV medication.

K. Carter asked when Bessie could discontinue use of antidepressant medication. K. Moore said she would likely take this for a while after, or at least a year. If a patient did not mind taking the medication daily, and if there were no negative side effects, it was okay to keep a patient on such medications. If people want to get off medication, they could, but they would be monitored. K. Carter said that medication can sometimes affect people badly and they might opt for more therapy. He felt that there was no one-size-fits-all mental health care. Once COVID-19 was over, K. Carter suggested, many people would be seeking mental health and Substance Use care. He hoped there would be more providers available.

K. Carter suggested that relapse was part of recovery. K. Moore said that perfection was hard to achieve, and if moderate use was the goal, “relapse” was much rarer. E. Thornburg asked about cultural stigma around seeking mental health. In this story, Bessie was a Black woman. In the Black community, she suggested, mental illness was sometimes considered Eurocentric or weak. She felt that this could mess with someone’s path to success. She asked about people who were committed to treatment, themselves, but were shamed out of treatment due to cultural stigma. K. Moore said that this definitely occurred with some patients, and generally speaking, seeking mental health care needed a more positive reputation. K. Moore explained that there was a lack of a larger cultural narrative around people getting better after mental health care and how hard people worked to feel better. This, he felt, should be celebrated.

K. Moore said a lot of data shows that the Black community entered psychotherapy at lower rates, even more so than Latinx communities. He felt that there were not enough therapists of color who were working and licensed in the field. K. Carter said that he saw this issue in his lifetime as well, with people turning away from therapy and opting to keep quiet about their mental illnesses.

N. Outland said that she had issues with the hero narrative, and that cultural narratives within the United States affected Black therapists as well. She felt there was gatekeeping within many institutions. In reality, she said there were many Black social workers and therapists on the call, currently. K. Moore agreed, but said that on a percentage basis, 80% of psychotherapists

identified as exclusively white when graduating from psychotherapy programs. Regarding funding and gatekeeping, he said there was only a fraction of money put into mental health services. They were dramatically underfunded. He suggested that mental health and addiction services, since they were so intertwined, should be funded at the same amount. Both should be met at an equal level with physical health, but this was never enforced. J. Williams said he had seen firsthand the absence of mental health providers to work with. He said there was an RFP for EHE around mental health that only received one applicant. A DExIS RFP around mental health last year received no applicants.

J. Williams said that the workforce acted as a huge barrier to providing competent services for populations who needed it. Some jurisdictions, he said, would see 40% of treaters and prescribers retiring in the next 10 years. In Philadelphia, this was not as much of an issue, but there were not enough clinicians specializing in what clients needed. For example, there might be a Black, gay man who was a therapist, but this person still might have had class privilege and could not relate to their clients in a deeper way. He said that they needed to access lower barrier training and how they could get people the training and licensing they needed. He agreed with N. Outland, but felt that they needed to look into workforce development as a whole.

K. Carter mentioned that mental health providers were not paid enough, so people also did not want to enter this field. People could not afford to work in the field. They needed to make the field more appealing in university, especially when people needed to pay student loans after graduation.

E. Thornburg mentioned that one barrier to care, as found in research, was patients not seeing themselves reflected in a care provider. For example, someone who was transgender did not want to continuously overexplain their gender identity. In this scenario, they might choose to continue without a provider if they continuously encountered this barrier. K. Moore agreed, emphasized the need for better training and ensuring providers were educating themselves. He noted that there were many stories about survival in sex work, addiction, the housing crisis, etc. where public assistance did not help much. Competent therapists were important. He said that the provider must continuously educate themselves. K. Carter asked if they had someone who was transgender at their care clinic. K. Moore said yes.

K. Moore turned to the next slide, noting that trauma affected people in different ways and that people behave differently depending. Next, he noted that harm reduction as the evidence-based, trauma-informed care was significant. He felt that every provider should have this type of care/approach.

K. Moore listed the specific skills that trauma-informed therapists should possess:

- Anxiety management skills
- Coping strategies
- Depression treatment
- Trauma processing for people who are in a good place in their lives

K. Moore explained that when someone faced trauma in their life (life-threatening or personal integrity-threatening), people get “stuck.” This may be all that they can talk about and may turn

to substance use. He said that once people could receive treatment for substance use, then they could work through their trauma more effectively with a therapist. Long-term therapy was always the most effective approach, he noted.

K. Moore last looked at the slide titled "Are psychotic people more dangerous than others?" The reason he thought it was important to bring this up was because he felt some people were scared of psychosis; but the truth was psychotic individuals were not more dangerous in terms of violence. Sometimes people might feel distress when talking to those who are psychotic, but this is a myth about violence.

K. Moore referred to the slide titled "Current Treatment: Motivational Interviewing." He said that this treatment assisted people in identifying their own motivations to change a health behavior. He said this was the most effective approach. Helping people make the changes they want to make was best, not suggesting which changes should be made.

K. Moore said he needed to wrap up the presentation, but he would love to continue the conversation and offered his contact information.

K. Carter asked if COURAGE provided other services as well. He said yes, Dr. T. Acri was an HIV specialist and they had more comprehensive services. D. D'Alessandro said she had not heard of COURAGE and asked for more information. K. Moore said that Courage was a local nonprofit that just opened this past January. D. D'Alessandro asked if they were an FQHC and if they wanted to be a RW funded organization. K. Moore said they were not RW funded but would like to be and that they were not an FQHC. He said they just received an award from the city for being a low-threshold sexual health service. They recently received their first city grant, and they had a mobile vehicle and would hopefully be an active community partner throughout Philadelphia.

J. Williams said AACO was always in need of new partners. He also mentioned the Latinx low-threshold sexual health RFP was still available to apply if anyone was interested.

Discussion Items:

—Literature Review on HIV and Aging—

J. Henrikson said she would offer a brief overview on what she had been working on since the beginning of the year. This was a literature review on aging and HIV which reviewed specific services and gaps as well as the growing presence of people aging with HIV. By reviewing literature, she gathered themes. Throughout the literature review, her goal was to find service procurement information and how this compared to services for aging individuals without HIV. Unfortunately, there was not a lot of literature around this. Therefore, the literature review summarized common themes based on existing research as well as research that was still needed. This information, especially the research that was still needed, could be used to assist with a needs assessment.

Most of the research she used was relatively recent and even included a 2021 publication. She found other literature from the 90s and early 2000s. She noted that the epidemic had changed since then, and that much of the research was also medical-based. These factors limited the amount of literature that was applicable to the review.

Within the literature review's introduction, she only referenced about half of the articles since much of the other literature was flooded with medical terminology and specifics. Additionally, these articles also reiterated the same themes. Her findings showed that over half of PLWH in the United States were over 50 years old and made up about 17% of new diagnoses. At this point in time, PLWH could live just as long and healthy lives as people living without HIV. However, PLWH over 50 still faced higher barriers at higher rates than their uninfected peers. She would later speak more on co- and multi-morbidities since this was a large part of the research. PLWH faced structural and socioeconomic barriers which complicated health equity. Within the literature review, she spoke on the shift in life expectancy, barriers PLWH face, issues of co- and multi-morbidity, and the issue of accelerated aging-- an issue on which, she pointed out, science was divided. She ended the literature review on the care needs of those aging with HIV.

As for the first topic, as she mentioned previously, there was the shift in life expectancy. Around this, she compiled articles detailing the shift pre- and post- ART. From a 2016 study, it showed that individuals treated properly had an "normal" life expectancy. Though an HIV diagnosis no longer led to shortened life expectancy, people could still engage in risky behaviors that shortened life expectancy. Some research, but not all, neglected to mention social determinants of health such as poverty which increased risky behaviors.

She explained that the main barriers for PLWH over 50 years old were the same as their younger counterparts but might occur more acutely. Aging PLWH faced more social isolation and might be due to stigma which made individuals hesitant to reach out to traditional support systems. She said that retention to care was also a common issue within the research which also could be linked to social isolation. These themes often intertwined and could create cyclical patterns.

Within an Atlanta study at a RW clinic, out of 144 responses, 81 patients had optimal and 64 patients had suboptimal visit adherence. The suboptimal respondents reported higher levels of loneliness and smaller social network sizes. It also noted that the suboptimal respondents also tended to have income lower than the federal poverty line, which she said, emphasized the effect of social determinants of health.

Additionally, there was literature on how provider perception influenced care people received. In a 2020 study, it was suggested that clinicians who work with PLWH did not take other gerryatric issues as seriously or consider them as much as they would or patients who were not living with HIV. While some barriers to care for aging PLWH were systemic, others could be done at the provider level, e.g. more comprehensive care for aging PLWH which takes agining into consideration.

Regarding co- and multimorbidities, this meant that someone had two or more illnesses or diseases at the same time. PLWH experienced age-associated health conditions earlier than their non-infected peers. A 2018 study found that multimorbidity and polypharmacy (simultaneous

use of multiple medications) were related to longer duration of HIV infection rather than older age. Multimorbidity occurred at a higher rate for PLWH for over 10 years as opposed to those living with HIV for under 10 years. In a 2020 study in Europe, it was found that PLWH had a higher chance of comorbidities than noninfective peers. This study also spoke of the need for a holistic care approach of PLWH. It mentioned how higher retention in care would also drive down risks associated with co- and multimorbidities.

As for accelerated aging, J. Henrikson noted that there was conflicted research and conclusion. HIV and chronic inflammation were linked which was why some conclusions had been drawn. There was some research regarding cognitive challenges for aging PLWH. However, this was a controversial topic. In the Journal of NeuroVirology, it found data supporting a model of accelerated neurocognitive aging in PLWH. However, this was not where memory, language, or speeded executive functions were studied.

Regarding specialized care, there were reports that showed a need for competent care. There was a reported need for LGBTQ+ competent positions. Some studies showed that patients continued to struggle to find providers that were competent in addressing their healthcare. A 2015 report found that out of 138 US academic faculty practices, there was a very low percentage of procedures and policies to identify LGBT-competent physicians.

Overall, her main conclusion was that there needed to be more research that addressed social determinants of health when discussing correlations between HIV and aging. Additionally, there were not enough studies discussing the lived experiences of PLWH accessing the care--instead, they focus on mortality and co- and multimorbidity.

D. D'Alessandro thanked J. Henrikson for her work and effort/presentation. D. D'Alessandro noted that she knew of someone who could offer a clinical update since they used to run an HIV practice at the health center. This person could likely present on a treatment update for those aging with HIV. Additionally, she said she was surprised about the cognitive impairment aspect of the research. She said psychiatry presenters she had heard present in the past, they expected to see more HIV dementia because of the inflammation in the brain. This was especially the case with perinatal-acquired HIV. This can be prevented with adherence to care. J. Henrikson said she wanted to ensure that she had sections regarding the importance of adherence to care for delaying/preventing negative effects HIV could have if untreated.

D. Gana said that social isolation had a physical impact on the body equivalent to smoking a pack of cigarettes daily. J. Henrikson agreed. D. Gana said, especially with the accelerated rate of the number of people aging with HIV. G. Grannan asked if there was information on PLWH who were 50+ and sexual health. K. Carter mentioned how there was not enough attention paid to sexual health and elders. J. Henrikson said there were studies that found people aging with HIV were more likely to be reluctant to discuss sexual behavior with physicians. This could lead to remaining untreated or diagnosed. She noted its relation to the theme of competent care teams. K. Carter emphasized the importance of physicians practicing proper sexual health intakes.

D. Gana said there needed to be more gerontologists who were knowledgeable about HIV. J. Henrikson said that HIV physicians were not usually in contact with gerontologists, so HIV care could occur in a vacuum and prevented comprehensive care.

L. Diaz thanked J. Henrikson for her hard work.

—PC Budget—

A. Edelstein said that the next item was the PC budget. He mentioned that the budget was reviewed by the Finance Committee in their meeting last week. They also reviewed the process for quarterly reporting of budgeted expenditures. He said he would discuss this later in the Finance Committee report.

M. Ross-Russell said, as part of the Site Visit, the HRSA consultants said that while HIPC approved the PC budget during the allocations process, they needed to have more information on the budget. On the budget, the personnel line was collapsed and the remainder of expenditures were listed. They moved away from doing this on a regular basis, because several members expressed discomfort with the review. This budget was presented to the Finance Committee at their last meeting in the beginning of June.

The budget represented the recently approved budget for the final award. The total award for PC Support was $497,378, which represented both formula and supplemental. This was based off of the allocations approved by HIPC last month.

Also listed was a breakdown of various direct costs such as rent, utilities, postage, etc. She said some of these numbers would likely change due to staffing changes, communications, rent, partial remote, etc. Listed were costs that were associated with in-person meetings. As they received information from PHMC (fiscal agent)/AACO, they could report back quarterly about changes in expenditures and why those changes occurred.

M. Ross-Russell said they were also anticipating the upcoming needs assessment process, especially the consumer survey. Costs involved with these would include postage, incentives, etc. Mailing the surveys out generally costs, on average, between $6,000-$10,000. They were anticipating this occurred toward the end of the year. These were the various items to keep in mind as they looked at the budget and planned for future activities.

L. Diaz asked if they were going to present this once a year. M. Ross-Russell said they would present this to the Finance Committee and HIPC on a quarterly basis, as it was updated. This would be similar to spending reports form AACO and would be based on invoices being submitted in a timely fashion. It would be their first time doing this on a quarterly basis. L. Diaz said she was uncomfortable seeing the budget, but she understood why it had to be presented. C. Steib asked L. Diaz to express why she felt discomfort. L. Diaz said looking at how much staff made in the personnel line made her uncomfortable. A. Edelstein said it was not a big deal to him since they were not looking at individual salary amounts. L. Diaz thanked M. Ross-Russell for the presentation.

Committee Reports:

—Executive Committee—

M. Ross-Russell reminded the Executive Committee that OHP staff would send out a Doodle poll to set up a date. This would likely happen at the end of this month or the beginning of next month.

—Finance Committee—

A. Edelstein said that the Finance Committee looked at the PC Budget (how to present it quarterly and expenditures versus budget) and also looked at the method for Monitoring the Administrative Mechanism, including the RFP process. These were both related to citations from the HRSA Site Visit. The Finance Committee looked at a form for Monitoring the Administrative Mechanism that OHP put together to get the process started. A. Edlestein said they decided to have the Executive Committee look further into these two citations to ensure that the two citations were being handled correctly.

D. D'Alessandro asked if HIPC had to have more of a role in monitoring the disbursement of funds. M. Ross-Russell responded, saying that HIPC had the role of monitoring the administrative mechanism as a legislative responsibility. Within this responsibility, was ensuring funds were spent in accordance with allocations determined by HIPC. HIPC was to determine funds, and monitoring and subcontracting, etc. was the recipient role. The other component was to manage how to review the RFP process. They had to ensure that money was being dispersed in a timely fashion. The three budget plans HIPC created were to ensure there was a plan in place so the recipient could immediately distribute funds within 90 days. In the case of a partial award, there was also a plan in place so the recipient could ensure money was distributed rapidly. She said A. Edelstein had alluded to ensuring the expenditures/funds for the community happened within the 90 day period. HIPC's process for monitoring had not necessarily been sufficient for HRSA up to this point, so HIPC needed to develop a process with the recipient to ensure this was happening as needed. A. Edelstein said that OHP's draft form for monitoring the administrative mechanism had a number of items that were different elements of the process. They could look, overall, at how the recipient presented the RFP process, distribution of funds, and contracts toward the goal of rapid distribution of funds.

—Nominations Committee—

No report.

—Positive Committee—

S. Moletteri reported that the Positive Committee would be meeting Monday at 7:00 p.m. to discuss the recruitment plan from the Ad-Hoc Recruitment Workgroup. They would also look into planning for a panel on mental health and social isolation.

—Comprehensive Planning Committee—

G. Grannan reported that they met last month and had continued to review the EHE plan and the local plan in preparation for allocations. Their next meeting would be a week from today at 2:00 p.m.

—Prevention Committee—

No report. C. Steib said he was not able to make the last meeting. They would next meet June 23rd at 2:30 p.m.

—Ad-Hoc Recruitment Workgroup—

S. Moletteri reported that the Ad-Hoc Workgroup met earlier this month to review their 3-goal draft recruitment plan thus far. They also discussed youth organizations to connect with to achieve some of their recruitment objectives. They did not have a future meeting date as of yet, but they would send out a Doodle poll to get a meeting date for July. They would likely talk more about further developing their third goal.

K. Carter mentioned that if anyone from NJ knew of youth organizations, email staff to let them know of them. S. Moletteri added PA Counties as well, since most of what they had was based in Philadelphia.

Any Other Business:

G. Grannan noted that there were political steps in Atlantic City to close the syringe access program. He felt they needed to do what they could to oppose it, though they could not do much since their EMA did not include this area. K. Carter asked if this included NJ as a whole or just Atlantic City. G. Grannan said there were 5 syringe access programs in NJ: 1 in Camden, 1 in Newark, 1 in Patterson, and possibly 1 in Trenton. Atlantic City was the first one in NJ, and it initially faced a lot of political opposition. The issue of opposition to syringe access programs, however, was bigger than NJ. K. Carter pointed out that those being served by these programs were typically POC. G. Grannan said that politically, in West Virginia, they were trying to close down their syringe access programs and that Scott County, Indiana was being shut down as well.

Announcements:

K. Carter announced that Connect the Dots was hosting a Mental Health and HIV Conference on October 8, 2021. It would be hybrid: 45 in-person and the rest virtual.

B. Rowley announced that the Abstract deadline for USCHA was June 25, 2021, so if people were interested in presenting or attending, they should apply ASAP.

K. Carter announced that National HIV Testing Day was June 17, 2021.

C. Steib announced that the Prevention Summit was going on through the month of June. He suggested everyone look into Philadelphia FIGHT's workshops. L. Diaz said she would be presenting a webinar on June 30th. D. Gana asked what her topic was. L. Diaz responded with mental health, noting that it was called Black, Brown, and Looking for Therapy.

D. Surplus announced that ACME Pharmacies in PA and DE (unfortunately not NJ) were able to administer mental health medications and even those for substance use, so she would put her information in the chat for any questions. She noted that flu season was also coming up, and those who received their flu shot at ACME Pharmacies would receive 10% off at ACME.

D. D'Alessandro announced that the Health Federation of Philadelphia had a series of discussions on compassionate quality healthcare for Substance Use/the opioid epidemic. This was mostly for providers working in the field, but everyone was able to join. It would be on Monday from 12:15-1:30 p.m., and a doctor from Jefferson would also be joining to discuss perinatal treatment for people who use opioids.

K. Carter announced that Philadelphia FIGHT was performing COVID-19 outreach starting next week to distribute vaccines to the community—go to the website for times and locations throughout the city.

Adjournment:

L. Diaz called for a motion to adjourn. **Motion:** A. Edelstein motioned, D. Gana seconded to adjourn the June 2021 HIPC meeting. **Motion passed:** Meeting adjourned at 4:18 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- June 2021 HIPC Meeting Agenda
- May 2021 HIPC Meeting Minutes