Meeting Agenda

VIRTUAL:
Thursday, August 19, 2021
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(June 17, 2021)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
  - Assessment of Telehealth Use
  - Consumer Survey and Upcoming Activities
- 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: Thursday, September 16, 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, June 17, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Sharona Clarke, David Gana, Pamela Gorman, Gus Grannan (Co-Chair), Gerry Keys, Clint Steib, Nicole Swinson, Adam Williams

Guests: Anna Thomas-Ferraioli (AACO), Julia Scarlett (AACO),

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

Call to Order/Introductions: G. Grannan called the meeting to order at 2:06 p.m. He asked everyone to introduce themselves with their name, their place of representation, and something they were happy about. K. Carter asked for introductions to be put in the chat since he and S. Moletteri had to attend the Planning CHATT Learning Collaborative (LC) for Recruitment and Retention at 4:00 p.m.

Approval of Agenda: G. Grannan referred to the June 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** C. Steib motioned, K. Carter seconded to approve the June 2021 CPC agenda. **Motion passed:** 70% in favor, 30% abstaining. The June 2021 CPC agenda was approved.

Approval of Minutes (*May 20, 2021*): G. Grannan referred to the May 2021 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the May 2021 minutes. **Motion**: D. Gana motioned, K. Carter seconded to approve the May 20, 2021 meeting minutes. **Motion passed:** 60% in favor, 40% abstaining. The May 2021 CPC minutes were approved.

Report of Co-Chair:
G. Grannan reported that his audio would soon improve, as he would soon have better reception.

Report of Staff:
M. Ross-Russell reported that OHP was currently in the process of preparing for Allocations. There was a lot of recently-released information, and OHP also had various reports to respond to for HRSA. The RWHAP application was released two days ago. This application was a three-year application as opposed to a one-year application. They also had to consider that, under normal circumstances, the Allocations Process was held over the course of three weeks in July. Because the process would be virtual, they would focus on one region per week. Both CPC and Prevention Committee would have to either postpone or cancel their July meetings since they interfered with the Allocations dates.

S. Moletteri reported that today was the last Planning CHATT LC Meeting and that it would occur, as K. Carter mentioned, at 4:00 p.m. A. Williams asked for more information on the LC. J. Henrikson noted that this was a Learning Collaborative on recruitment. S. Moletteri said it was hosted by Planning CHATT and had participation from Planning Councils across the nation to learn and share information about recruitment and retention efforts.

Discussion Items:

—Literature Review on HIV and Aging—

J. Henrikson pulled up the literature review she had been working on regarding HIV and Aging. She noted that the majority of council members had heard her presentation during HIPC on the 10th. Therefore, she would offer a summary of her findings by discussing the conclusion and highlighting the portions that addressed needs assessments and were more goal-oriented. The goal-oriented findings could offer ideas for CPC or the council to explore if it interested them.

She was also happy to go over the literature review in detail if the council requested. K. Carter felt that a quick summary with the inclusion of any relevant goals would be sufficient. G. Grannan agreed.

J. Henrikson reported that the literature review, at first, was supposed to address common concerns for resource and service procurement for PLWH 50+ and how it compared people living without HIV. She notified everyone that there was a lack of literature comparing the two experiences. If she were to discuss the comparison, she would have to extrapolate which was not appropriate for a literature review. Instead, because of the lack of comparison between care for those living with and without HIV, the literature review addressed common themes.

J. Henrikson summarized the abstract of the literature review, noting that with the advent of ART and other medical interventions, life expectancy of PLWH had lengthened drastically. Currently, 51% of PLWH were 50+ years old, and this population was growing. The review would look into health outcomes of PLWH 50+ and how they could better be improved.

In total, there were five sections within the review. The first section discussed life expectancy and why PLWH were able to live longer lives. The second discussed section barriers to receiving care for PLWH. The next discussed co- and multi-morbidities--there was a lot of research focused on this. Additionally, she had attended a few conferences that also discussed this topic. A lot, as she said, was written by and for practitioners and was medical-focused. There was not substantial information on the social and sociological aspects. The next section discussed accelerated aging of PLWH. The final section discussed specialized care interventions currently being operationalized or how they could be used best to help the aging population of PLWH.

J. Henrikson listed the main takeaways. One of them, she explained, was that even though PLWH had the same life expectancy as their peers living without HIV, barriers to care and increased participation of mortality-increasing behaviors such as smoking affected mortality rate. Biosocial markers and social determinants of health were often the cause behind increased “risk behaviors.” Such social determinants included environmental racism and systemic racism. This was not a focal point of the research that she uncovered.

Another takeaway, she said, was that PLWH faced a higher burden of co- and multi-morbidities relative to peers who were not PLWH. She focused on articles which discussed how to approach care for PLWH in a holistic way, meaning they deeply considered PLWH as they aged while addressing social determinants of health. This type of research, she noted, discussed a further-reaching approach that would not isolate, but instead bring together all relevant factors for proper care of PLWH who are aging.

The idea, she said, of a holistic approach was reiterated in the final, specialized care section of the literature review. It reiterated the need for more LGBTQ+ focused care as well as those who were specialized in HIV care. In all, there was a lack of competent providers.

In the conclusion, she discussed that although the articles shed light on needs and experiences, they did not address goals. They also failed to compare and contrast care for PLWH to those living without HIV. The continued theme of "aging" was necessary to understanding barriers to care and retention in care. In other words, it was important for research to exist that was an evidence-based understanding of how people's ability to navigate health care systems influenced quality of life and life expectancy. This brought to light that a needs assessment would be interesting. This could help to uncover where people aging with HIV felt that services were lacking and where/how things could be improved.

Hearing directly from PLWH who were aging within the EMA would be important to equity in care, increased happiness, and increased life expectancy. She asked about people's thoughts on a needs assessment. K. Carter asked if any of the articles highlighted the importance of a competent pharmacist and any barriers to care when iterating with pharmacists. J. Henrikson said that there were a couple articles about poly-pharmacy, or taking multiple medications due to co- and multi-morbidities. She did not find any research about pharmacist relationships or roles, however. K. Carter said that interactions that may occur between medications, especially when someone who was aging was taking more medications. J. Henrikson was surprised at how much research focused solely on co- and multi-morbidities. Research that focused on physicians more so discussed the effects of HIV on a person's health as opposed to looking into the experiences of aging. They receive an equal amount of research or emphasis when providing care. Though she wanted to avoid generalizing the studies, she felt she must highlight this recurring theme.

C. Steib asked if she had reached out to individuals from the Elder Initiative, since they might be able to answer some lingering questions from the literature review. J. Henrikson responded that she reached out to hospitals and providers that directed her to studies. Sheh had not reached out to the Elder Initiative, though they might be a vital connection moving forward. K. Carter said he had sent the local PCA plan and the National Plan on Aging, as they would be helpful for a needs assessment. J. Henrikson said that the literature review focused on existing literature, though bringing in other resources such as local and national plans and the Elder Initiative would be great to bring in for a needs assessment. C. Steib was in favor of a needs assessment for this, as this was an important topic. D. Gana agreed, reiterating that over 50% of PLWH were over the age of 50. They needed to look at the long term issues PLWH who were aging would have and how RW could accommodate them better.

J. Henrikson agreed, saying the literature review was important for highlighting current discussions. She noted that a lot of the literature was based in different contexts, so focusing on the EMA would be necessary in identifying specific needs. K. Carter suggested they look into mobility as well and see if RW could fund incontinence pads, wheelchairs, etc. He said that specialized case managers for senior-related health issues were also vital for PLWH who were aging. J. Henrikson said that this also fit into how they would be looking forward to EHE and how aging individuals fit into the plan and ending the HIV epidemic.

K. Carter also mentioned the sexual history issue with providers—older adults did not want to talk about their sex life and neither did providers. J. Henrikson agreed, saying that research showed higher stigma for sexual health in older populations. She had not focused on testing and prevention in the literature review, but it would be important to know more about this. For PLWH, the risk of acquiring other STIs was still relevant in provider settings.

J. Henrikson suggested that moving forward, she could put together a model for a needs assessment. Afterwards, everyone could look over and build on the needs assessment plan if they would like. K. Carter asked if it was reasonable to have it done after August or September. J. Henrikson said they could decide when would be best. She added that they would have to consider the IRB and within the process. She would be able to create a draft by August or September. She would not submit to the IRB before the CPC had seen, adjusted, and approved it.

—Allocations Process—

M. Ross-Russell reported that they would now discuss the allocations process and how they would continue with it. Since they were still social distancing and unable to have in-person meetings, allocations would occur online.

Right now, OHP was in the process of uploading and refining materials. They had not yet worked out the order of the three regions. However, based on the same model they used last year, the process would occur over a period of three weeks. Tuesday would be informational; they would receive information regarding region and services, and would consider all information based on whether or not the issues being discussed were funding issues, system issues, or directive issues. Wednesday would be an optional Q&A so they could discuss any questions or concerns regarding Tuesday. Thursday would consist of the actual allocations component where they could review the three different budget scenarios based on the region's share of the epidemic.

The reason allocations impacted CPC was because one of the three weeks would overlap with the next CPC meeting. She asked how they wanted to handle this. In the past, CPC had canceled their meeting for the month of July, especially because of the amount of meeting time dedicated to allocations.

K. Carter asked how much time they dedicated to each day. S. Moletteri said that each meeting last year was two hours. K. Carter asked if there was anything CPC could do to assist OHP with allocations. M. Ross-Russell responded that OHP was covered for now, but thanked him.

M. Ross-Russell said OHP was brainstorming how to cover as much information as possible without staff taking up too much meeting time. When they covered the informational section, it would be about services or other components that would be helpful to explain given the amount of information and detail on the website. However, it was still important that people reviewed all of the information available on the website.

K. Carter asked if the service categories booklet was available on the website. M. Ross-Russell said she had not yet updated it, but it would be completed shortly. Included in the booklet would be service definitions, service utilization, other RW funding parts, service need, and information from the recipient for concerns and consideration. She explained that the expenditures under each service category would be impacted by COVID-19 since there was an unusual amount of underspending. They would discuss the impact of COVID-19 and how it would continue into the current year. As a caveat, she would remind the group that they were deciding allocations for next year, FY2022. Hopefully, the impact of COVID-19 would be resolved by then and they would have historically "normal" spending trends. She had most of the information to update the booklet, and she just needed to get input from the recipient.

K. Carter reminded everyone that they made their decisions based on documented need. He asked if COVID-19 would make decision-making more confusing. M. Ross-Russell responded, based on the brief COVID-19 survey, what HIPC knew as barriers prior to COVID-19 were still barriers. Still, they would have to refer to AACO for information as well. Typically, individuals with a lower income still expressed the same concerns as before COVID-19. HIPC was actively trying to tackle and reduce these barriers.

A. Williams asked if information for emerging topics would be gathered and considered. M. Ross-Russell said that emerging topics would come up within the discussion and that documented need was required, not just anecdotal, for decision-making. A. Williams asked what was considered evidence of documented need. M. Ross-Russell responded with the EPI, needs assessments, focus groups, data, etc. Another example was that COVID-19 showed more utilization for mental health--likely due to isolation--which sparked conversation within the council. Every question was important, and she was available to answer any and all.

G. Grannan mentioned that there was more underspending than usual because of COVID-19. He asked if there were any providers expecting a "snap back." In other words, he was curious as to whether there would suddenly be an uptake in service utilization since individuals had not been receiving services regularly. M. Ross-Russell was not certain and could only guess. She said that part of the underspending was due to remote work which lowered overhead/programmatic costs. Telemedicine also made the use of transportation obsolete in virtual scenarios. However, in other scenarios, transportation costs increased due to an uptake in more costly modes of transportation, e.g. private transportation in lieu of public transportation.

She explained that the government had also distributed a lot of COVID-19 related money, which was to be used prior to RW funds, since RW was a payer of last resort. She said this was for housing, rental support, etc. They would not be able to spend down RW dollars completely if COVID-19 money was there. There were also instances where people were not accessing COVID-19 funds related to housing possibly due to the moratorium on rent. She explained that

this did not mean individuals did not have to rent, however. Therefore, it was not clear what would happen in June 2021 when the moratorium ended. All of these concerns, she explained, would hopefully be answered this year..

M. Ross-Russell reported that there was typically between $300,000 and $400,000 in underspending each year, and this was due to using other funding streams first. This year, however, underspending was closer to $1.5 million. K. Carter said that was a big change and a large sum of money. For housing, homeless services said they had a new Emergency Housing Voucher program where they were to distribute 863 vouchers to help with homelessness. Hopefully, this would help, but it might also generate more underspending. M. Ross-Russell said there were a lot of moving parts and everyone was trying to make the best decisions while still realizing there were difficulties and unanswered questions.

K. Carter asked if they should add another +/- percentage budget scenario. M. Ross-Russell said they could, but that there was a written policy/process associated with the budgets. They needed to follow the process, and any deviation was grievable. They would have to revisit the policy. She explained that percentages had changed over the years. They had moved from level funding to a 3% + or - change. They changed it to 5% +/-, because that was generally the cap for the fluctuation in the award (generally a decrease). If the award increased, it was typically closer to a 1% or 2% change, closer to level. If there was only a small change in the award and it was closer to level funding, there was just a proportional increase or decrease. K. Carter said he understood--he only stated this because they wanted to ensure they had all their bases covered.

G. Grannan said the CPC would likely have to cancel the July meeting since it conflicted with allocations. He asked if there was any discussion or objection. K. Carter said it would make much more sense for them to meet in August, after allocations. P. Gorman, D. Gana, and C. Steib agreed. No vote was needed.

C. Steib asked if the Prevention Committee could also discuss allocations and meeting dates during their next meeting on June 30th. J. Henrikson said this would be included in the agenda.

Action Items:

—Recommendations from May CPC Meeting—
S. Moletteri reported that these were the recommendations/directives as discussed in the May meeting. They had changed “96 hours” to “96 business hours” based on the discussion and concern the CPC had around the first directive listed. They could feel free to change it back. They said that the committee did not want to vote on this until they heard more from AACO about the implementation of EHE around these two topics. Additionally, they said, that CPC asked OHP to reach out to other EMAs to see how they were dealing with, specifically, ART. S. Moletteri said that M. Ross-Russell spoke with other EMAs about ART and could report back on this, though they did not think she received much feedback. They also said that A. Thomas-Ferraioli from AACO was in attendance to speak on the two directives and how they related to EHE.

A. Thomas-Ferraioli said she could either offer a short summary or offer questions. K. Carter asked if, based on the language of the first directive, people would not start until Saturday or Sunday. S. Moletteri responded that this likely depended on the operating hours of the actual provider which the second directive addressed. M. Ross-Russell said, if memory served, the CPC wanted to take into consideration the information around EHE implementation and wanted to hear where they were in this process from the recipient. S. Moletteri agreed, saying that the committee wanted to know more about whether there were data indicators created to measure the two directives which consisted of language pulled directly from EHE.

A. Thomas-Ferraioli said she had prepared to talk about Immediate ART as well as extension of office hours. She explained how Immediate ART was being implemented in two areas: under (1) EHE-specific funding and (2) more generally/broadly. First, Immediate ART was a required activity for providers awarded EHE reengagement contracts. They were funded by HRSA-20-078 and PS-20-2010 (CDC money), not Ryan White. These were the two grant names covering the EHE-specific activities. Immediate ART was a required activity under these contracts.

The contracts, A. Thomas-Ferraioli stated, were designed to fit around RW services, extend practices, and achieve some sort of innovation. The funding was meant to reduce barriers to reengagement. All providers had different, unique barriers. Therefore, there was no timeline since agencies all had to move at their own pace.

She defined Immediate ART as operationalized within 96 hours of diagnosis. Ideally, providers would start their patients on ART on the same day they were diagnosed (same-day start) if they had capacity. There were logistical barriers to this, but as she said, this was the most ideal delivery of ART.

Separate from this, supported by EHE resources, was the work of the Philadelphia Regional EHE Collaborative. She recently announced this at the last HIPC meeting, letting everyone know this would be in occurrence. She would be sending out invitations to the various working groups. Immediate ART would be a working group of the collaborative. They would work on why Immediate ART was recommended as a best practice and how to implement ART (some individuals would be further along in the implementation process and could share their hands-on knowledge). She explained that the collaborative was required in the EHE reengagement contract. They would also be available to other clinical programs regardless of funding source.

In terms of systems for measurement of ART, this was still being developed and they were early in the funding period. ISU was developing a system to collect this information around Immediate ART.

In terms of the other item, expanded operating hours, A. Thomas-Ferraioli said that providers were expected to expand hours based on the reengagement contract. Similar to the approach to Immediate ART, AACO would work with agencies to identify unique barriers and create strategies. This area was harder, she observed, because agencies reported a number of barriers (lack of clinical personnel, lack of buy-in from hospital systems, security issues, etc.), so they were working with the providers to overcome these barriers. They were also reviewing how telemedicine could be leveraged to provide extended access.

M. Ross-Russell asked about the reengagement contracts and how they were related to ART. If there were patients who were newly diagnosed and they were not reengaging in care, what would happen with the remaining providers who provided services to those new to the system and not reengaging. Additionally, she asked about providers without the reengagement contract. A. Thomas-Ferraioli said that nonengagement contractors did not have requirements around this at the time, but they could participate in the working group and work towards the offer of having Immediate ART in their settings. K. Carter asked the timeline of the contract. A. Thomas-Ferraioli responded that the HRSA-20-078 contracts were from March 1st – February 28th, just like RW. One agency, she said, was funded by the CDC from the PS-20-2010 contact. This contract went from August 1st--July 31st. They were both in the years that ran through 2025. K. Carter asked how the contracts were awarded. A. Thomas-Ferraioli explained that there was a competitive RFP process and five agencies were awarded.

D. Gana said that, going back to the directives, he felt that 96 business hours should be changed to just 96 hours. A. Thomas-Ferraioli said, based on other language, that was correct. K. Carter asked for more clarification on extended operating hours, because he felt this was too open-ended. A. Thomas-Ferraioli said it was defined as hours outside of the 9 a.m.-5 p.m. business hours. This could mean before 9:00 a.m., after 5:00 p.m., or on weekends. This was open-ended so that providers could work as they needed. K. Carter felt that all agencies could have the same hours so there was some sort of consistency. A. Thomas-Ferraioli said each funded setting was starting at different points, so the clinical hours offered depended on resources, staffing, etc. This was all outside of what a funder could dictate or pay for. K. Carter clarified that this was just for the City of Philadelphia. A. Thomas-Ferraioli agreed that the EHE funding was within city limits.

K. Carter noted how there were specific guidelines for starting ART and which combination medications to use. He asked if this guidance was provided to the awarded agencies. A. Thomas-Ferraioli responded that AACO referred clinicians to clinical guidelines in existence and agencies were expected to follow them in combination with their judgment as clinical providers.

J. Henrikson asked if they wanted to move forward with this, considering that they would be voting to bring these to the allocations process. G. Grannan felt it made perfect sense to send the directive language directly to the allocations process, since HIPC would have to approve the language as a whole in the future. S. Moletteri clarified that they would only vote on the first two, and that the third point was just a future discussion for the Planning Council.

A. Williams said, if he were to vote on the two directives together, he agreed with the first but not the second. He felt that it did not benefit the patient to mandate Immediate ART. He agreed that expanded operational hours were necessary, however. He felt that providers, once a diagnosis occurred, did not fail to provide Immediate ART unless clinically indicated otherwise. For example, a patient might have to wait for a genotype or they had to consider comorbid conditions. If it was mandated, prescription of Immediate ART would be harmful. K. Carter said that the maximum amount of time for Immediate ART was 96 hours. Also, Immediate ART meant providers did not have to wait to prescribe ART. They could offer ART, take necessary

labs, and then wait for their patient to return. The idea of Immediate ART was to ensure that providers did not lose patients to care because of a delay in treatment.

A. Williams felt there were medically valid reasons that prescribers would hold off from prescribing ART. K. Carter said that this was a recommendation from the CDC and HRSA. A. Williams asked if this meant they were not in accordance with this. D. Gana clarified that this recommendation was from the EHE guidelines. He said they were trying to conform to the language for the federal guidelines.

A. Williams said that inconsistent adherence to medication could lead to ineffective treatment and resistance to some medications. He wondered what would happen if an individual was not ready to be adherent to medication. Would a prescriber want to hold off in this scenario? P. Gorman said that readiness and other factors could potentially make a patient not yet ready for ART and adherence to ART. They, as the provider, would document this. A. Williams felt that providers should not feel pressured to prescribe Immediate ART if they felt it was not in the best interest of their patient. P. Gorman said that there were extenuating situations that would prevent Immediate ART, but Immediate ART was still the gold standard for EHE. She said that in clinical settings, they could always identify, within their notes, any exceptions and why. She felt there was no issue with generalizing Immediate ART as a standard, because ultimately, it should always defer to the clinician and their expertise depending on the patient. Clinical documentation within a chart, even if it went against policy, would be acceptable. D. Gana said they should also be looking at the more common occurrences, not the exceptions. A. Williams just wanted to ensure that they were not putting vulnerable populations at risk.

M. Ross-Russell said that they could bring this discussion around clinical documentation to the allocations discussion. They could vote on the current language to bring to allocations. This did not mean the language was finalized, it just meant it would be introduced during the allocations process. OHP could present the CPC language along with the concern around clinical documentation, so those participating in the allocations process could decide what would be best language-wise. A. Williams was appreciative of this, since he did not want to create health hazards for patients. M. Ross-Russell noted that the interest in this directive was due to the fact that some providers were not starting people on ART for months. They were not even close to following the guidelines. She said that there were still providers not following the guidelines. Unless clinically indicated and recorded otherwise.

D. Gana said that the first directive's language needed to be changed to exclude "business" and include "after diagnosis" at the end. This would change the first directive to: In accordance to federal treatment guidelines, increase access to immediate ART initiation (within 96 hours after diagnosis).

A. Williams asked that, even though they would not include it within the motion right now, that they consider "unless otherwise clinically indicated and recorded" within the allocations process for the first motion. C. Steib agreed, saying that even if A. Williams was not in attendance at allocations, it was still recording in writing, so OHP staff could bring it up during allocations.

Motion: D. Gana motioned to present the two CPC recommendations (with the new, proposed language for the first recommendation) during the allocations process for their consideration, C. Steib seconded.

Vote:

G. Grannan: abstain
C. Steib: in favor
K. Carter: in favor
A. Williams: in favor
D. Gana: in favor
P. Gorman: in favor
N. Swinson: in favor
G. Keys: in favor

Motion passed: 7 in favor, 1 abstaining, 0 opposed.

G. Grannan said, like M. Ross-Russell mentioned, this was not the end point. They would bring the discussion about clinical indications up within the allocations process. The current language just acted as a framework.

Other Business:
None.

Announcements:
None.

Adjournment:
G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the June 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:51 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- June 2021 CPC Meeting Agenda
- May 2021 CPC Meeting Minutes
- Recommendations from May 2021 CPC Meeting