Meeting Agenda

VIRTUAL:

Thursday June 16, 2022

2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(May 19, 2022)*
- Report of Co-Chairs
- Report of Staff
- Discussion Item
  - Priority Setting
- Other Business
- Announcements
- Adjournment

Comprehensive Planning Committee

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Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, May 21, 2022
2:00-4:00 p.m.

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Debra D'Alessandro, Gus Grannan (Co-Chair), Mike Valentin, Adam Williams

Guest: Sanzida Anzuman (AACO), Melanie Mercado

Staff: Beth Celeste, Sofia Moletteri, Mari Ross-Russell, Elijah Sumners

Call to Order: G. Grannan called the meeting to order at 2:09pm

Excused: Gerry Keys, Greg Langan

Approval of Agenda: G. Grannan presented the May agenda for approval. **Motion**: K. Carter motioned, D. D'Alessandro seconded to approve the May 2022 agenda. **Motion passed**: 3 in favor, 1 abstained.

Approval of Minutes *(April 21, 2022)*: G. Grannan presented the previous meeting's minutes for approval. **Motion**: K. Carter motioned, D. D'Alessandro seconded to approve the April 2022 meeting minutes. **Motion passed**: 2 in favor, 2 abstained.

Report of Co-Chairs:
No Report.

Report of Staff:
S. Moletteri reported that OHP was still receiving surveys from community members in the EMA and there were about 70 submitted online so far. Most have been from Philadelphia, so the focus was to get more PA county representation in order to get a more comprehensive view on the entire EMA. Additionally, there have been 26 provider requests and OHP has extended the deadline for the survey completion to June 30th. M. Ross-Russell reported that OHP has sent out close to 2,000 survey packets, and the breakdown by region would be about 400 to New Jersey and the PA counties, respectively. Certain counties were less represented than others, but overall OHP was trying to ensure that the respondent sample was as representative of the epidemic as possible.

M. Ross-Russell reported that the people who were going to be impacted were those community members who live in areas where there were not completed surveys. Additionally, Dr. Brady sent out another letter which prompted more providers to not only respond, but request surveys. As of this meeting she believed there were only two survey requests pending left to be mailed out. She anticipated that survey requests should be finished and sent out by

the beginning of next week.

K. Carter asked if the sample size was too small would OHP still use the information gathered through the survey? M. Ross-Russell stated that it depended on what the data showed. OHP received a small sample with the COVID-19 survey. This was a limitation and that would be how it was presented. Considering that close to 2,000 surveys have gone to providers, OHP was still dependent on providers to send out those surveys. G. Grannan asked if the problem was also the volume of surveys to worry about skewed data? M. Ross-Russell answered affirmatively and stated that ultimately it was the responsibility of the providers who have requested the surveys to make sure they were sent out to community members. M. Ross-Russell asked what the response was from the providers that were contacted by E. Sumners. E. Sumners responded that most of the providers had received packets and they were waiting to either get them back from the clients to send to the Office of HIV Planning or they had pre stamped postage and were expecting them to send it to the office directly.

Discussion Items:

–Priority Setting Process–

S. Moletteri reported that at this point in the priority setting discussion the Comprehensive Planning Committee had voted on 17 service categories and there were 12 to vote on during this meeting. S. Moletteri explained that the committee were going to utilize Community Survey data from 2017. The committee would also be given a definition of the service category and discuss noteworthy information about the service. S. Moleterri explained that the vote scale was 1, 5, or 8. One meant that this service was not critical for vulnerable populations, or an emergent need. That did not mean that the service was not important, but it was just not critical in comparison to others. Five meant you believe that the service was critical for vulnerable populations and emergent need. If you vote eight, that meant it was a priority need for vulnerable populations and emergent need.

S. Moletteri reported that Medical Transportation is the provision of non-emergency transportation for people to get to their core and support services. The following were not allowed as a rule of all services: direct cash payments were not allowed, direct maintenance expenses (tires, repairs, etc.) of privately owned vehicles and any other costs associated with privately owned vehicles such as lease loan payments, insurance license, or other fees. As for the consumer survey data, about 1/4 of respondents missed an appointment in the previous 12 months because of transportation problems, that same amount used to transportation as well.

S. Moleterri reported that 11% needed transportation, but did not receive the service. Most people were able to receive the transportation that they wanted, but there was still a number of people that did not and there were still people who ran into problems, even if they eventually got the service. As for the program guidance, it can be provided through provider contracts. In a previous meeting council members stated that their provider had a contract with Uber or other rideshare for mileage reimbursements, purchase lease of organizational vehicles, so organizations own vehicles, volunteer drivers, vouchers, and SEPTA tokens. This was the highest reported need at intake for 2020/2021. Ryan White is a payer of last resort and people must use Logistic Care first. There has been discussion about problems with Logistic Care within the council in the past.

D. D'Alessandro asked what it meant to use Logistic Care first and what if they could not meet the needs of the client? M. Ross-Russell answered that to her understanding Logistic Care was the approved Medicaid/Medicare provider in this area in this region, and it's not that you can only Logistic Care. You have to demonstrate that the use of this service presents a barrier. If the organization has a transportation line in their budget, then the client could use Uber and then have the recipient, reimburse them for the use of that costs, and just document the fact that they have consistently had issue with getting the individual to care as a result of the use of Logistic Care. S. Moleterri read the results of the poll: one vote for a 5 or critical, and three votes as an 8 or priority.

S. Moleterri reported the next category was Housing Assistance and it provided transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ ambulatory health services and treatment, including temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. S. Moletteri reported that it must provide clients with medical/supportive services or enable access to services and it cannot be used for mortgage payments. According to the 2017 Consumer Survey data 14% were staying with friends or family, 2.1% lived in a shelter, 1.1% were in transitional housing, and 0.8% lived on the street. In the "Worth Noting" section S. Moleterri reported that 7% of those who use Ryan White services have temporary housing and nearly 6% have unstable housing. This was reported by the Office of Homeless Services, and it estimated that 5,700 individuals were considered to be homeless, and a little under 1,000 of those people were unsheltered. The total of 75.8% of Ryan White clients live below 138% of the federal poverty level, which is 17,236 people in 2019 and that number was currently approximately 20,000 people. S. Moletteri reported that this service category was the second highest reported need at intake and very close to transportation at 51.4%.

K. Carter asked if money from COVID-19 came into play regarding this service category? M. Ross-Russell answered that there were COVID-19 funds that were made available for a shallow rent program and the issue was that the COVID-19 money was spent first. There was underspending last year. K. Carter asked if the Office of Homeless services goes to canvas the city and do they take the OHP surveys with them? M. Ross-Russell answered that historically based on information from housing services, especially those experiencing homelessness, that their status mattered and who they were around mattered when the conversation happens.

M. Ross-Russell reported that the tendency was to not disclose one's status or to have one's status discussed when other individuals were preseent. Conducting a survey could potentially be problematic, and that was a survey of any kind, whether it was from OHP or someone else. Depending on the questions that are being asked, it could be problematic unless you can get the person in a one-on-one setting because they were usually sharing space with someone else. These were things that we try to take into consideration as part of that process without putting respondents in a potentially dangerous situation. S. Moleterri reported the results of the poll were two votes as a 5 or critical and two votes as an 8 or priority.

S. Moletteri reported the next service category was the Food Bank/ Home Delivered Meals and it referred to the provision of actual food items, hot meals, or a voucher program to

purchase food. This included the provision of essential non-food items that are limited to personal hygiene, household cleaning supplies, and water filtration/ purification systems in communities where issues of water safety exist. The 2017 Community Survey data stated that 30% reported using this service in the last 12 months and 10% recorded needing it but not being able to receive it in the last year. S. Moletteri reported that the Food Bank service category was the third highest reported at intake per CSU at 37.8%. Unallowable costs included household appliances, pet food, and other non-essential products. According to The Office of Homeless Services' data from 2019, it was estimated that one in five Philadelphians were food insecure. S. Moletteri reported the results of the poll were two votes as a 5 or critical and two votes as an 8 or priority.

S. Moleterri reported the Legal/Other Professional Service category involved professional/licensed help with legal matters related to or arising from HIV, including benefits assistance, discrimination because of HIV status, power of attorney, living wills, permanence planning– counseling for custody and placement of minors after a parent/ caregiver is either deceased or can no longer care for them, and tax preparation. According to the 2017 Consumer Survey data, 12% reported needing, but not getting this legal service or other professional services in the last 12 months. It cannot be used for criminal cases.

G. Grannan stated that given that criminalization was one of the structural inequities we have to work with, as a council and also more specifically with particular populations. It is troubling to me that there was no legal support for criminal cases. He stated that he had been threatened with criminal charges for drug distribution for distributing naloxone in the past in NJ. D. D'Alessandro agreed with this sentiment and stated that as a payer of last resort the argument would be every jurisdiction has a mechanism for public defenders for criminal cases.

M. Ross-Russell reported that when OHP received policy clarification notices specifically how the services defined what can and cannot be done come directly from HRSA. The reality is that it goes back to legislative language and the federal language specifically. S. Moleterri reported the results were one vote as a 5 or critical, and three voting it as priority.

S. Moleterri reported that the next service category was Outreach Services. Outreach provided the following activities identification of people who do not know their status, linkage or reengagement of people who have HIV to health care coverage options, and reengagement, specifically, of people who know their status to ambulatory/outpatient health services. These three activities made up the service category. The consumer survey data showed 12% reported using the service to get reengaged to care and 8% reported needing the service, but not being able to get it. This cannot be delivered anonymously due to the intrinsic need for follow-up within the service. This service cannot exclusively promote HIV prevention education. It may be used for HIV testing. So, this is not education based. This is really about re engaging and identifying people to get them into care. And in 2019 10% of people living with HIV and Philadelphia were unaware of their status. And if I'm remembering correctly, that accounted for 30% of new cases. Within the PA counties, one in three people had a concurrent AIDS diagnosis with their HIV diagnosis, the least number of people with a concurrent diagnosis was in Philadelphia.

K. Carter asked if the EHE plan also covered similar services? S. Moletteri answered affirmatively that it was the first pillar of the EHE plan and this covered populations that have been hard to reach and getting people diagnosed. S. Moleterri reported the results, one voted it as an 5 or critical, and three voted it as a priority.

S. Moleterri reported that the next service category was Respite Care. This was a provision of periodic respite care and community or homebased settings that include nonmedical assistance designed to provide care for eligible clients to receive a primary caregiver responsible for their daily care. This wasn't used by a lot of people and according to the 2017 consumer survey only 2% utilized it; although 11% did report needing assistance, but not getting it. The program guidance states that it is only available for licensed or certified provider settings, and cannot be used in for social or recreational settings.

D. D'Alessandro asked if this included respite childcare? M. Ross-Russell answered affirmatively that respite care could include children. Respite care could be either for a child or adult and allowed the primary caregiver time to take care of other things or allowed the PLWH access to medical and or support services. The primary thing about respite care was that that there must be a direct corollary benefit to the individual who was positive. D. D'Alessandro stated that there used to be a dedicated respite and childcare provider in our area, but they no longer exist. M. Ross-Russell said that there were volunteer organizations that have provided this service in the past as well. It was also something that in some instances were provided in hospital settings. S. Moleterri shared the results of the poll were one voting as a 1 not critical, two as critical, and 1 as an 8 or priority.

S. Moletteri reported that the next service category was psychosocial support services. This often has to do with support groups, but can also include group or individual support and counseling services. Activities could include bereavement counseling, caregiver/respite care, child abuse, and neglect counseling, HIV support groups, nutrition counseling provided by a nonregistered dietitian. Nutrition counseling and pastoral care/counseling services therapy required registered/licensed practitioners. There were a lot of people that reported attending support groups during the last 12 months in the 2017 consumer survey at 30% and 9% needed support groups but did not receive them. Religious based counseling could be included in this service. It has been discussed that amidst COVID-19 safety regulations, how social isolation and need for connection have been noted and growing and that social support is important for health and well-being. S. Moletteri reported the results were two voting as 5 or critical, and two voting as a priority.

S. Moletteri reported that the next service category was health education/risk reduction. This is the provision of education to clients living with HIV, about HIV transmission and how to reduce this, for example, getting your partners on PrEP and treatment as prevention. Health education on health care coverage options, health literacy and treatment adherence education. The 2017 consumer survey data where .3% of sexually active participants said that their HIV negative partner was on PrEP. According to the data 15.6% of their partners were not taking PrEP. Then for HIV medical care information about PrEP was offered to 16.6%. Of the sample, disclosure support was offered to 13.8%. Less than half of people living with HIV who reported sexual and substance use behaviors were offered any harm reduction, STI

testing, or other prevention interventions during their medical care visits.

K. Carter asked if during the COVID-19 pandemic if there was an uptick in the PrEP prescriptions or did there still need to be an effort to educate primary care providers? G. Grannan added that there was much resistance among providers to education, as if they cannot accept that they may be a barrier. A. Williams cited a report from the Philadelphia Department of Public Health which stated that indications vary significantly by race ethnicity, with higher proportions of people of color and an indication for PrEP and all risk groups based on recent survey of PrEP prescribers. PPH estimated that a minimum of 2,790 individuals were on PrEP, which was 21% of all people with an indication in Philadelphia in 2018. For a PrEP gap of 10,023 individuals. Additionally, the ongoing opioid crisis in Philadelphia has overwhelmed the existing syringe service programs in Philadelphia. S. Moletteri reported the results were three voting it as an 8 or priority and one as a 5 or critical.

S. Moletteri reported the next service category was ADAP a state administered program authorized under Ryan White Part B to provide FDA approved medications. It may also be used to provide health insurance for eligible clients to enhance access to adherence to medical care. According to consumer survey data, ADAP was the second most used service at 20%, followed by Medicare Part D at 34%. Next was patient assistance at 7% followed by other insurance at 7% and 5% of people paid for their medications. ADAP funds cannot be used LPAP support.

A. Williams asked for LPAP to be defined. M. Ross-Russell answered that it stood for “local pharmaceutical assistance program. It was usually the program that was utilized before somebody was plugged into all of the other systems of care, meaning that when someone first entered into the system, if they needed to obtain access to Medicaid, etc and they have no other way of paying for their for their medications. Local pharmaceutical Assistance Program is what we use to support their medications. It's usually for 14 days, it could be used for a longer period as well. S. Moleterri reported the results were three votes as an 8 or priority and one as 5 or critical.

Other Business:

None.

Announcements:

None.

Adjournment:

G. Grannan asked for a motion to adjourn. D. D’Alessandro motioned to adjourn. K. Carter seconded the motion. The meeting was adjourned at 3:57 p.m.

Respectfully submitted,

Elijah Sumners

Materials Included:

IHAP Checklist

Priority Setting Presentation

Key Considerations