MEETING AGENDA

VIRTUAL:
Thursday, November 9th, 2023
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes (October 12th, 2023)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - Notice of Funding Opportunity - Division of Disease Control
  - MidAtlantic AIDS Education and Training Center
- Committee Reports:
  - Executive Committee
  - Finance Committee – Alan Edelstein & Adam Williams
  - Nominations Committee – Michael Cappuccilli & Juan Baez
  - Positive Committee – Keith Carter
  - Comprehensive Planning Committee – Gus Grannan & Debra Dalessandro
  - Prevention Committee – Desiree Surplus & Clint Steib
- Other Business
- Announcements
- Adjournment

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org
The next HIV Integrated Planning Council meeting is
VIRTUAL: January 11th, 2023 from 2:00 p.m. to 4:30 p.m.
Please contact the office at least 5 days in advance if you require special assistance.

Staff Directory

Mari Ross-Russell - Director, Finance Committee
Email: mari@hivphilly.org

Tiffany Dominique — Prevention Committee
Email - tiffany@hivphilly.org

Debbie Law — Nominations Committee
Email - debbie@hivphilly.org

Sofia Moletteri— Comprehensive Planning Committee, Poz Committee, Website
Email: sofia@hivphilly.org

Kevin Trinh — Minutes & Attendance
Email: kevin@hivphilly.org

Beth Celeste — Reception
Email: beth@hivphilly.org

Philadelphia: HIV Integrated Planning Council
Meeting Minutes of
Thursday, November 9th, 2023
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Michael Cappuccilli, Keith Carter, Debra D'Alessandro, Jose Demarco, Lupe Diaz (Co-Chair), Alan Edelstein, Pamela Gorman, Jeffrey Haskins, Sharee Heaven (Co-Chair), Gerry Keys, Greg Langan, Lorett Matus, Erica Rand, Desiree Surplus, AJ Scruggs, Evan Thornburg, Adam Williams

Guests: Anna Thomas-Ferraioli (DHH), Ameenah McCann-Woods, Maddison Toney (DHH), Caitlin Conyngham (DHH), Veronica Brisco, Kenneth Cruz-Dillard, James Ealy, Nafisah Houston, Sterling Johnson, Alecia Manley, Jerome Pipes, Mystkue Woods

Excused: Gus Grannan

Staff: Beth Celeste**,** Debbie Law, Tiffany Dominique, Sofia Moletteri, Kevin Trinh

Call to Order: S. Heaven called the meeting to order at 2:07 p.m.

Introductions: S. Heaven asked everyone to introduce themselves.

Approval of Agenda: S. Heaven referred to the November 2023 HIV Integrated Planning Council agenda and asked for a motion to approve. **Motion:** K. Carter motioned; D'Alessandro seconded to approve the November 2023 HIV Integrated Planning Council agenda via a Zoom poll. **Motion passed:** 15 in favor, 3 abstained. The November 2023 HIV Integrated Planning Council agenda was approved.

Approval of Minutes (*October 12th, 2023*): S. Heaven referred to the October 2023 HIV Integrated Planning Council meeting minutes and asked for a motion to approve. A. Williams had a correction for page 11. The minutes recorded that J. Williams was unable to answer A. Williams' question in the chat. A. Williams said this was untrue and that J. Williams had refused to answer the question. D. D'Alessandro said they may have been in the process of forming a relationship with Health Center 1 and were not able to provide more information until they had more concrete information. A. Williams felt there was a difference between being unable to answer the question due to contractual reasons and refusing to answer the question. He wanted the record to show there was an honest attempt to obtain information and there was a refusal from the recipient. D. D'Alessandro said she wanted to add the word "discharge planning meeting with Philadelphia correctional healthcare staff" to the second to last sentence on page 11 where she said they held a Health Federation discharge planning meeting every other month. **Motion:** K. Carter motioned; G. Keys seconded to approve the amended October 2023 HIV Integrated Planning Council minutes via a Zoom poll. **Motion passed:** 16 in favor, 6 abstained. The amended October 2023 HIV Integrated Planning Council meeting minutes were approved.

Report of Co-Chairs:
None.

Report of Staff:
S. Moletteri informed the new members that it was a custom to have their cameras off for the ZOOM meeting but camera use was not prohibited in any way.

D. Law said they had sent out the letters of recommendation to the Mayor's Office for signature, but they were not yet returned. D. Law said she would be emailing the new HIPC members with updates on the situation.

K. Trinh stated that the new members were welcome to contact the staff if they had any questions or concerns and placed the contact information for the staff members in the chatbox.

J. Demarco asked for more information on their application process including how often they reviewed applications. S. Moletteri said they receive applications year round but reviewed them in the fall and spring. D. Law said they aimed to review applications twice a year if they received enough applications. She encouraged the HIPC members to find potential members who may be interested in joining to apply through the OHP website. This round, they received 20 applications including veteran members who reapplied. D. Law said they were preparing for their fall orientation.

J. Demarco asked if there were persons in HIPC who were under the age of 30. S. Moletteri replied there were some people in HIPC and that HIPC's age demographics had closely matched the overall demographics of the epidemic.

D. D'Alessandro reminded the HIPC members that the meeting and the chat were not anonymous and were recorded in the minutes for public viewing.

J. Pipes said he had not received the letter of appointment yet and asked if it would prevent him from voting. S. Heaven reminded the HIPC members that they could not vote unless they received their letter of appointment.

T. Dominique provided the HIPC members to the OHP website in the chatbox with a link to a glossary of terms and acronyms that each member could use.

Presentation (20:00)
-Integrated Plan: Diagnose and Prevent-
A. Thomas-Ferraioli introduced herself as the End the Epidemic (EHE) Advisor at the Philadelphia Department of Public Health (PDPH). She would be presenting on PDPH's Integrated Plan and update HIPC members on the progress of the Treat Pillar, Progress Pillar, and the Develop the HIV Workforce Pillar of the plan. She would address questions after each section.

The first Pillar discussed in the presentation was the Treat Pillar. A. Thomas-Ferraioli would read the three goals and then the activities to reach the goals. She would update the HIPC members on

the progress of the goals. The goals of the first pillar were to reach 95% of persons living with HIV (PLWH) virally suppressed by 2026, to reach 95% of PLWH engaged with HIV medical care by 2026, and to eliminate disparities in HIV outcomes.

A. Thomas-Ferraioli then listed the key activities in goal 1 objective 1. The objective was to increase the uptake of Immediate Initiation of Antiretroviral Treatment (iART) among eligible persons newly diagnosed with HIV to 95%. Key activity 1.1 was to increase access to iART initiation within 96 hours. Key Activity 1.2 was to continue to support an established low-threshold HIV treatment site in an underserved area of Philadelphia designed to serve people who inject drugs (PWID). Key activity 1.3 was to support and explore other low-threshold treatment models for HIV care (e.g., telemedicine, nurse-extended visits, pharmacy-support HIV care) throughout the jurisdiction. Key activity 1.4 was to provide technical assistance in high-volume substance abuse treatment programs to diagnose HIV immediately, immediately initiate ART, and link PLWH to HIV medical care. Key Activity 1.5 was to continue to support efforts to expand access to the AIDS Drug Assistance Program (ADAP).

A. Thomas-Ferraioli defined iART as the initiation of ART treatment within 96 hours of diagnosis from the first reactive test. She reported that PDPH had an EHE Learning Collaborative iART Working Group that was open to all EMA care providers. PDPH had a 2 phase EHE-funded iART Project. The first phase was completed by Ryan White (RW) Outpatient Ambulatory Health Services Providers. She said that phase was completed in March 2023 and they were in phase 2. The second phase iART project was conducted by Diagnosing Providers in Philadelphia from October 2023 to March 2024. Concurrently, all EMA providers, including New Jersey providers, were encouraged to use RW Part A funds to implement iART. All EHE-funded providers were required to develop a protocol using a checklist of required components to ensure relative uniformity across providers. The protocols were for iART and rapid restart for people returning to care. They were also required to implement the approved protocol and begin reporting data on time from the first reactive test to treatment start.

Key Activity 1.2 referred to the Sana Clinic. In response to the ongoing outbreak of HIV infection among people who inject drugs in Philadelphia, the PDPH Division of HIV Health (DHH) was funding a low-threshold storefront HIV treatment clinic called the Sana Clinic at Prevention Point Philadelphia (PPP), a local syringe services program (SSP). Since the creation of the clinic, PPP noted an increase in viral suppression and adherence to medication as more clinic patients have transitioned to injectable ART. As of March 2023, 11 of 55 patients (20%) were on injectable ART, and 23 of 55 (42%) patients were virally suppressed at the time of the report. At last count, 17 Sana patients were provided the mpox vaccine. A. Thomas-Ferraioli said they were observing a recent decrease in visits from the program high of 65 active participants down to 38 in the most recent reporting period. A. Thomas-Ferraioli said there were several causes for the decrease. One of them was several participants who had passed away due to overdoses. Others were moved out of the area against their wishes.

For Key Activity 1.3, PDPH DHH set up one shop stop and other DHH-funded sites to which PWID could be referred. These sites provide services not limited to HIV treatment, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), Hepatitis C treatment, medically assisted therapy (MAT), and distribution of prescriptions for Naloxone. The DHH Field Services

Program, through the Data to Care initiative, conducted outreach, linkage, and re-engagement services to PWID who have been diagnosed with HIV who were not in care or were in care but not virally suppressed.

Key Activity 1.4 involved DHH working with their regional managed care Medicaid behavioral health payer, Community Behavioral Health (CBH). DHH and CBH supported the implementation of routine HIV screening at entry into Substance Abuse Disorder treatment intake across CBH's network, which includes the rest of the EMA in Pennsylvania. DHH provided resources and support for providers who were not connected to the HIV treatment and support services system.

A. Thomas-Ferraioli then read the second objective under goal 1. The second objective was to re-engage 95% of PLWH who were out of care in HIV medical care. Key activity 2.1 was to increase re-engagement in HIV medical care by maintaining existing PDPH DHH data-to-care (D2C) activities and collaborating with the Pennsylvania Department of Health (PADOH). In cross-jurisdictional D2C activities. Key activity 2.2 was to expand operating hours in RW-funded Outpatient Ambulatory Health Services (O/AHS) to include evening and weekend appointments for HIV medical care. Key activity 2.3 was to evaluate the need for additional medical case management services at RW-funded clinical sites. Key Activity 2.4 was to strengthen the multidisciplinary team approach by supporting and evaluating a pilot program to add community health workers at one designated RW medical clinic to implement Managed Problem Solving, an evidence-based intervention.

DHH collaborated with the state of PA on D2C activities for people who move between Philadelphia and the Pennsylvania and New Jersey counties for care. DHH established a data-sharing agreement with New Jersey to share lab data across jurisdictions to support D2C efforts. DHH established a data-sharing agreement with New Jersey to share lab data across jurisdictions to support D2C efforts.

A. Thomas-Ferraioli then spoke about the EHE Engagement and Reengagements Programs. DHH had 6 subrecipients and A. Thomas-Ferraioli announced that there would be 2 more in the coming weeks. The 6 subrecipients currently were the Penn Medicine, Temple University Hospital, Mazzoni Center, Jefferson Hospital, and Einstein Hospital. The program's objective was to engage and re-engage PLWH in the city of Philadelphia to treat HIV and improve viral load suppression. Agencies were required to conduct core activities that address multiple work plan objectives. These core activities included responding to data, participating in D2C activities, expanding low-barrier service delivery initiatives, providing iART, expediting linkage to HIV care, and implementing MAPS+.

Goal 1, objective 3 was to assess the needs of people aging with HIV in the jurisdiction including long-term survivors and more recently diagnosed people with HIV over 50. Then the objective was to identify and implement strategies to support identified needs. A. Thomas-Ferraioli reviewed the key activities and strategies to reach this objective. Key activity 3.1 was to review available literature on social and health challenges for people aging with HIV, as well as evidence-based strategies to improve health outcomes among people aging with HIV. Key Activity 3.2 was to consult with stakeholders and community members regarding proposed

strategies to support people aging with HIV. Key Activity 3.3 was to identify delivery providers through request for proposal (RFPS) based on needs identified from the review of the literature, consultations, and available funding.

A. Thomas-Ferraioli provided progress on the goal 1 objective 3. DHH conducted EHE Community Consultation in partnership with the Elder Initiative. DHH also held the first Aging and Thriving symposium on May 23, 2023. The symposium was open to community members across the EMA and was promoted at HIPC ahead of the event. DHH planned to schedule the second annual symposium for May 2024. A. Thomas-Ferraioli encouraged the HIPC members to save the date. DHH was also developing focus groups with partners at the University of Pennsylvania on the service needs of older adults. DHH was developing a learning collaborative for DHH subrecipient providers on how to be aging-ready HIV services providers, which would be open to all EMA providers. A. Thomas-Ferraioli then thanked the members of HIPC who were involved with the Aging Symposium. These HIPC members were K. Carter, J. De Marco, A. Scruggs, and D. D'Alessandro. She then listed the aging and thriving workshops.

After thanking the HIPC members for their support, A. Thomas-Ferraioli reviewed the second goal of the Treat Pillar. The first objective was to address the social and structural influencers of health to reduce barriers to engagement in HIV medical care for PLWH who seek behavioral health care, housing, and supportive services. Key 1.1 of this objective was to reduce the barriers to behavioral health care by expanding service access through a partnership with the Department of Behavioral Health and Intellectual Disability Services. Key Activity 1.2 was to increase the coordination of mental health care and HIV care for PLWH through the integration of additional behavioral health consultants using the Primary Care Behavioral Health model of targeted health assessment, short-term intervention, and brief follow-up. Key Activity 1.3 was to pursue the implementation of a transitional housing program to assist PLWH who were rent-burdened or experiencing homelessness with the goal of permanent housing by providing short-term transitional housing with an intense medical case management component. Key Activity 1.4 was to support homelessness prevention activities by providing direct emergency financial assistance for rent and utilities in the EMA. Key activity 1.5 was to ensure medical case managers continue to assess and address housing instability when developing assessments and completing and reviewing clients' service care plans. Key activities 1.6 was to address transportation barriers for medical appointments and other necessary services. Key Activity 1.7 was to support the integration of trauma-informed approaches to HIV care. Key Activity 1.8 was to continue to provide necessary linguistic services. Key Activity 1.9 was to provide supportive services that reduce individual barriers to engagement in care and treatment adherence (i.e., Food Bank/Home Delivered Services, Emergency Financial Assistance, transitional housing, etc.).

A. Thomas-Ferraioli was excited to announce that the State Rebate-funded Transitional Housing Program was launching in 2024. She said PDPH DHH was in pre-implementation of the program. The first funded site was in Philadelphia with a plan to expand to Pennsylvania counties in the future. The program employed a housing-first approach. No sobriety preconditions were required for housing placement. The program was available for income-eligible individuals and households impacted by HIV who were homeless, housing insecure, or rent-burdened. The goal of the program was to transition participants to permanent housing.

A. Thomas-Ferraioli moved to Goal 2, objective 2. The objective was to provide more public-facing information on the availability of HIV treatment and supportive services for PLWH. Key activity 2.1 for this objective was to increase visibility of and increase awareness of the Ryan White HIV/AIDS Program-funded (RWHAP) service delivery system to people who were underinsured and uninsured to reduce barriers to care related to affordability. Key activity 2.2 was to reduce HIV stigma by including health equity and cultural barriers to care related to affordability. Key Activity 2.3 was to develop and distribute rights-based consumer medical education, including toolkits for PLWH. Key activity 2.4 was to increase the capacity of PDPH DHH-funded HIV care providers to implement evidence-based new and expanded activities, through technical assistance activities to improve health outcomes of PLWH. Key activity 2.5 was to maintain a public online data dashboard presenting local EHE-related information that displayed key performance indicators for providers including retention and viral suppression metrics for individual RWHAP-funded medical facilities. Key Activity 2.6 was to continue ongoing data dissemination to key community partners and internal and external stakeholders to increase knowledge, close information gaps, and provide educational resources to empower PLWH. Key activity 2.7 was to promote awareness among providers and PLWH regarding the availability of injectable ART options, which may contribute to improved engagement in care and viral load suppression (VLS) for patients with barriers to adherence. Key activity 2.8 was to ensure that non-digital and diverse mechanisms were used to disseminate information to address the digital divide.

A. Thomas-Ferraioli updated the HIPC members on the progress of the objective. She said DHH was developing status-neutral and HIV treatment-focused pages on Phillykeeponloving.com on the following topics: paying for HIV care, new diagnosis, stigma, personal stories, knowing your rights, getting into HIV care, and HIV treatment information. DHH was also developing an online resource finder tool for HIV prevention, care, and support services across the EMA. The resource finder was to be a searchable and filterable tool that could be used on a phone or computer to search for local resources. A. Thomas-Ferraioli said focus groups were being conducted soon to get community member insight on service and service-finding needs. A. Thomas-Ferraioli assured the HIPC members that the Health Information Helpline was available for people who preferred to consult a person. The number to the helpline was (215) 985-2437.

A. Thomas-Ferraioli moved to Goal 3, objective 1, which was to eliminate disparities in HIV outcomes. The objective was to address health equity disparities in RWHAP-funded HIV care facilities. Key activity 1.1 for this objective was to pilot health equity assessments and follow-up staff surveys at select provider sites. Key Activity 1.2 was to pilot test with select providers the low literacy health guide specific to HIV developed by PDPH DHH. Key activity 1.3 was to evaluate pilot programs for lessons learned and best practices. Key Activity 1.4 was to expand efforts to all funded treatment providers in the EMA.

A. Thomas-Ferraioli then moved to Goal 3 Objective 2. The objective was to expand the evaluation of HIV care programs to reduce health disparities. Key Activity 2.1 was to implement benchmarks based on lessons learned from the evaluation of pilot programs. Key activity 2.2 was to continue Health Resources and Services Administration (HRSA)/HAB measures for all RWHAP-funded services. Key Activity 2.3 was to analyze public health data to evaluate health

outcomes for priority populations. Key Activity 2.4 was to implement continuous improvement projects to address noted disparities in services.

DHH provided health equity assessments and plans. DHH helped providers identify practices that need to be changed. Providers would make a plan to make changes that were monitored by DHH. A. Thomas-Ferraioli then spoke about the Health Equity Institute. She announced that the first year-long series for EHE-funded providers was completed on November 8th, 2023. She thanked E. Thornburg for her role in the series. A. Thomas-Ferraioli said there was a voluntary series for medical case management (MCM) providers available through the MidAtlantic AETC. She stated it has completed 6 sessions of the first cycle with 6 remaining. DHH had ongoing program monitoring and evaluation, including monitoring of disparity data.

After reviewing the Treat Pillar, A. Thomas-Ferraioli paused for questions. There were no questions. The presentation moved forward to the review of the Respond Pillar.

A. Thomas-Ferraioli said the Respond Pillar referred to outbreak response. She said there were two goals. The first goal was to identify and investigate active HIV transmission clusters and respond to all HIV outbreaks. The second goal was to ensure data sharing with the Pennsylvania and New Jersey Departments of Health.

She started by reviewing objective 1 of the first goal. The objective was to maintain a robust core HIV public health data system to identify outbreaks of HIV. Key Activity 1.1 was to increase the capacity for HIV-related lab reporting. Key Activity 1.2 was to maintain capacity for molecular HIV surveillance activities and cluster review. Key Activity 1.3 was to maintain capacity for mobilizing outbreak response in case a cluster or outbreak was identified.

Objective 2 was to maintain outbreak response plans and structures to respond to outbreaks and clusters that require an escalated response. Key activity 2.1 was to immediately convene a cross-divisional working group including all divisions interacting with the community impacted by the outbreak when an escalated response was required. Key Activity 2.2 was to direct or re-direct existing HIV prevention and care program activities to intervene in the outbreak/cluster. DHH sought to quickly implement the outbreak response plans as necessary to respond to rapidly growing networks of HIV transmission. Key activity 2.3 was to implement any enhanced interventions identified in the Outbreak Response Plan and/or developed in response to the outbreak. Key Activity 2.4 was to implement a communication strategy to inform and recommend actions for providers and stakeholders. Impacted by the outbreak. Key activities 2.5 were to monitor and evaluate the escalated outbreak response. Key activity 2.6 was to streamline systems of data management to avoid duplication, enhance data linkage, and ascertain death.

A. Thomas-Ferraioli then spoke about Goal 1 objective 3 of the Respond Pillar. The objective was to intervene in all clusters that were identified. Key activity 3.1 was to initiate an Outbreak Response Plan (ORP) within 72 hours of an outbreak declaration. Key activity 3.2 was to enact continuous evaluation of the ORP throughout a determined outbreak. Key activity 3.3 was to conduct an overall evaluation of the activities of the ORP once a determined outbreak has been contained. Key Activity 3.4 was to summarize and report the activities of the ORP for a determined outbreak once the outbreak has been contained.

Goal 2, objective 1 and 2 was to expand and implement data sharing with the New Jersey Department of Health. Key activity 1.1 was to expand data to care activities. Key Activity 1.2 was to coordinate cross-jurisdictional response. Key activity 2.1 was to pursue the feasibility of coordinating a cross-jurisdictional outreach response team.

A. Thomas-Ferraioli brought up a line graph with the title "HIV Outbreak Among PWID in Philadelphia." She said she would provide some background on the topic as well as the work that PDPH DHH has been doing. She said PWID was historically heavily impacted in Philadelphia. SSPs began legally operating in Philadelphia in 1992, after then-Mayor Ed Rendell signed Executive Order 4-92, authorizing SSPs as a public health tool to address HIV. HIV cases peaked the same year with 819 new cases. Since 1992, new cases have fallen continuously until 2016, when there were 32 new cases. In 2018, an outbreak was identified among PWID, and there has been an active response since that time. On the next slide, A. Thomas-Ferraioli presented more recent information on new cases of HIV in recent years. In a bar graph titled "Newly Diagnosed HIV Cases by Quarter Among Persons Who Inject Drugs, Philadelphia, 2018-2022," A. Thomas-Ferraioli showed the HIPC members that as time progressed, the number of PLWH who were virally suppressed was decreasing. She noted they believed that in 2020, there was a dip in the number of cases due to underreporting due to COVID-19. She turned to the next slide with a bar graph with the title "Characteristics of PWID Diagnosed in Philadelphia 2021 - 2022." She said it was more likely that a person who was middle-aged, male, non-Hispanic White, and PWID to be a newly diagnosed case of HIV. She said people who were Hispanic and Black were impacted as well. She then said men who have sex with men were reported as a risk factor.

A. Thomas-Ferraioli then reviewed the activities DHH conducted for the Respond Pillar. A. Thomas-Ferraioli said some of the activities were covered in the last HIPC meeting when DHH reviewed the Diagnose and Prevention Pillars. Some activities were covered in the Treat Pillar. She said DHH continued to monitor the outbreak in terms of epidemiology and surveillance. DHH coordinated with the Pennsylvania Department of Health and New Jersey Department of Health on any outbreaks identified to extend outside Philadelphia. DHH has produced and distributed communications including health advisories. The most recent health advisory was called "Increase in HIV Diagnoses in People Who Inject Drugs." DHH distributed plain language outbreak advisory to PDPH DHH prevention and treatment providers, emergency departments, mobile people who use drugs sites (PWUD), and through the Substance Use Prevention and Harm Reduction (SUPHR), the Division of Disease Control Viral Hepatitis Programs, Resource Hubs, and STD programs. DHH had also sent health alert flyers for the population in both English and Spanish. A. Thomas-Ferraioli said DHH was working with their CDC partners to evaluate the response to identify effective strategies to better understand the current population. A. Thomas-Ferraioli then showed the HIPC members pictures of the flyers they distributed. The flyers presented information about knowing where to test for HIV, using PrEP, condoms, and ART. It also included a one-sized one-stop shop folded card that did not mention HIV or Hepatitis to protect the privacy of the person. The card contained a list of free/low-cost clinics offering care for physical and mental health. She said they had just queued a large print order of the materials that would be distributed in the coming weeks to their provider networks. DHH provided messaging to providers. If a client tested positive for HIV, the provider

was instructed to link to treatment. If the client tested negative, they should be connected to prevention resources. She then showed the HIPC members resource links where they could find more information on testing and treatment on websites such as PhillyKeepOnLoving and SubstanceUsePhilly.

A. Thomas-Ferraioli then commented on xylazine in the local street drug supply. She said on December 8, 2022, the Philadelphia Department of Public Health issued a health update regarding the increased presence of xylazine in street drugs. Xylazine was associated with increasing fatal overdoses and extensive severe wounds. Wound care needs could be emergent in nature, leaving HIV discussions a lower priority for patients. A. Thomas-Ferraioli said SubstanceUsePhilly.com has published informational resources and has started to distribute xylazine test strips, which became available on the market in March 2023.

With the conclusion of the review on the Respond Pillar, A. Thomas-Ferraioli asked the HIPC members if they had any questions about the section she just covered. A. Williams said the presentation did not mention the city health centers for treatment, prevention, or risk reduction. A. Thomas-Ferraioli said the mention of the health centers, specifically Health Center 1, was included in the flyers. A. Williams responded that Health Center 1 did not count as it was from a different division and did not provide primary care unlike the other eight city health centers. A. Thomas-Ferraioli said she would double-check that the other city health centers were mentioned. A. Williams said this was important, especially when considering health deserts where people could not get access to free health care for HIV screenings.

J. DeMarco asked how many clusters had been identified. A. Thomas-Ferraioli replied that there were small clusters that had been identified from time to time and were worked through field services. She said she did not know the exact number because they were handled in a routine non-outbreak way. The most notable cluster was the PWID outbreak. J. Sterling asked if there were racial or gender dynamics to the outbreaks. J. DeMarco replied that there was. A. Thomas-Ferraioli referred back to the slide about demographics in the Respond Pillar. She said they knew that HIV transmission was more likely to occur in people who were assigned male at birth than female at birth. Current information on gender was not always available and was filled in by the surveillance team. She said HIV transmission was more likely for people who were White but they were observing an increasing number and frequency of people who were Black and Hispanic who were diagnosed with HIV. DHH was monitoring this. J. Sterling remarked it was unexpected that the White population would more likely be impacted by HIV transmissions. A. Thomas-Ferraioli replied that there were many stereotypes associated with HIV transmission. She said that though more white people were diagnosed with HIV, HIV transmissions disproportionately affected the Black and brown populations.

T. Dominique asked what DHH's progress toward 95% viral suppression in PLWH. A. Thomas-Ferraioli said viral suppression was improving and they were currently at 70-79% viral suppression. She reminded the HIPC members that the goals were created before the COVID-19 pandemic which had exacerbated barriers to care.

A. Thomas-Ferraioli reviewed the Workforce Pillar of the Integrated Plan. The main goal of the pillar was to increase the capacity of the HIV workforce to provide quality, diagnose, treat, and

prevent services. The first goal of the pillar was to provide training related to health equity issues and other work-related topics. The second goal was to expand on the radical customer service approach at the provider level. The third goal was to support the efforts of funded providers to diversify their HIV workforce. The fourth goal was to continue to expand PDPH training opportunities, education, and technical assistance for frontline staff on HIV testing and linkage to care, HIV treatment, and HIV prevention including non-occupational Post Exposure Prophylaxis (nPEP) and PrEP. Progress on this pillar was through the Health Equity Institute. DHH incorporated radical customer service concepts into DHH-funded programs across the EMA. For example, concepts were incorporated in EHE Engagement, Sana Clinic, iART protocol approaches.

J. DeMarco asked if there was funding to hire PLWH since they may be more familiar with the PLWH community. A. Thomas-Ferraioli noted an overlap of the PLWH community and their workforce. She said DHH encouraged subrecipients to diversify their workforce and hire people with lived experience from their communities. They also made sure to compensate key informants for their time and expertise, like at the Aging Symposium for example. J. DeMarco said he had heard rumors that the EHE program was to be defunded in the future and asked if funding would continue. A. Thomas-Ferraioli said that was a fair question. She said all government programs came with a caveat that they could be defunded in the future at any time. She said they could not predict how the federal government would change the budget in the future. D. D'Alessandro said federal funding would depend on the 2024 election. J. DeMarco was concerned about the future of Medicaid and protections for LGBTQ+ individuals. He said HIV medication was expensive and he was worried that obtaining the medication would be more difficult in the future due to LGBTQ+ discrimination.

A. Thomas-Ferraioli thanked the HIPC members for the invitation. She put her email in the chat and encouraged the HIPC members to contact her if they had any questions.

-Directives Response-

A. Edelstein, the co-chair of the Finance Committee said the recipient (DHH) had replied to the directives that were sent to them from HIPC. Each county presented its directives. A. Edelstein read each directive and the recipient's response to the directives.

He read the directives from the New Jersey Counties first. The first directive stated that HIPC wanted to encourage outreach to aging populations to ensure they were informed about funded services.

The recipient's response to this directive was that they had and would communicate to their subrecipients that they must conduct outreach to aging populations to ensure they were aware of funded services in the EMA. Priority services to spread this message would primarily be done through medical case management and O/AHS-funded sites. The recipient would also research to determine whether this language can be integrated into contractual language.

The second directive from the New Jersey Counties was to increase access to and awareness of telehealth options for medical and social service care. HIPC requested more information on telehealth services provided and the circumstances of its use.

The recipient replied that telehealth options at multiple Ryan White outpatient/ambulatory sites have already been integrated into HIV primary care since the beginning of the COVID-19 pandemic. In August 2023, the recipient completed an update on telehealth options, this included platform-specific telehealth (Doxy.Me, Doximity, Electronic Health Record Platforms, ZOOM etc.). The recipient stated that despite telehealth services quickly becoming the norm, further research was still needed to learn how these providers made their patients aware of telehealth services through multiple methodologies. The recipient recognizes that individuals receive messages in multiple ways. Ensuring communication was clear would result in increased access to telehealth services across services.

The recipient said some subrecipients were already implementing certain initiatives such as pager services, distributing free cell phones, and patient portals. However, these services were highly targeted to specific patients who had a history of falling out of care or had been identified as needing extra support.

Regarding social services, the recipient said the bulk of Ryan White services must be conducted in person. However, there were some exceptions for medical case management and substance abuse services. Telehealth services were provided to those clients on an as-needed basis.

The third directive from New Jersey stated HIPC's request to ensure subrecipients were disseminating information on the availability and coverage of Emergency Financial Assistance (EFA) services. A. Edelstein said the primary mechanism by which EFA services were shared was through MCM (Medical Case Management). The recipient required all medical case managers to complete a vigorous training process with the recipient's MCM Coordination Project. Through this training, they were introduced to the EFA service category. More specifically, each medical case management program must designate an individual(s) who completes further training with PHMC to carry out the services properly. A client's needs were considered during their comprehensive assessment with their assigned medical case manager.

Furthermore, the recipient would be adding a service search tool on Philly Keep On Loving website. This would describe services and PLWH would be able to contact the recipient's Client Services Unit (CSU) staff via chat, email, or phone to ask questions about services. The recipient's response said that anyone in need of the service would be referred to MCM services and CSU would provide short-term case management until the client has been assigned an MCM.

D. D'Alessandro, who was a part of the Health Federation, wanted more information about the required training with PHMC. A. Edelstein said the response had specified PHMC because the organization handled the management for the EFA program for the recipient. A. McCann-Woods confirmed that this was correct.

The fourth directive from the New Jersey Counties was a request for the recipient to report back to the Comprehensive Planning Committee (CPC) with progress and updates on the currently implemented EFA-Housing Model.

A. Edelstein read that the EFA-Housing intended to provide EFA for limited one-time or short-term payments to assist the RWHAP client with an emergent need for paying for essential utilities, housing, food (including groceries, and food vouchers), transportation, and medication. EFA could occur as a direct payment to an agency or through a voucher program.

The recipient reported that through FY22, $107, 446, was allocated and the subrecipient had exceeded program goals. In total, 235 clients received 235 monthly payments for EFA-Housing. EFA-Housing has not encountered significant challenges. However, different situations were not written in guidance or service provisions that must be handled uniquely on a case-by-case basis. The recipient was excited to report that the processing of applications continued to be completed in 1-2 business days.

A. Edelstein read that increasing access to iART had been part of the HRSA EHE initiative for Philadelphia. The recipient had organized the following: an HIV Learning Collaborative as part of the EHE initiative, provided capacity for building assistance to all EHE-funded providers to develop and implement iART policies that included processes on access and expansion. In September 2023, the Recipient awarded all Status Neutral HIV testing providers to develop and implement iART policies to be completed by January 2024. Implementation of said iART policies across all EHE-funded subrecipients was now in force.

A. Edelstein read that the major caveat was additional funds to implement were only available as part of EHE efforts and those funds could only be awarded to providers in Philadelphia. RW Part A providers in New Jersey were encouraged to implement iART with their current Part A funds.

The sixth directive from the New Jersey Counties was a request to expand operating hours to include evening and weekend appointments for HIV medical care in community and hospital-based HIV treatment sites.

The recipient's response stated that they were expanding hours as part of the EHE efforts. Additional funds to implement were only available to Philadelphia-based providers through HRSA EHE funding and those funds can only be awarded to providers in Philadelphia. RW Part A providers in New Jersey were encouraged to expand operating hours with their current Part A funds.

The recipient would research internally the number of subrecipients who have expanded their hours of operation (including nights and weekends) with comparisons from FY21 to FY22. Additionally, the recipient would learn the proportion of patients and clients who utilize these services over a snapshot time in the same periods.

A. Edelstein moved to review the Pennsylvania Counties. He asked S. Moletteri to skip the directives that were similar to the previous county's directive. The next directive that was not shared with New Jersey's Counties was the Pennsylvania Counties' second directive. The directive requested that the recipient encourage outreach to aging populations to ensure they were informed about funded services.

A. Edelstein moved to the third directive from the Pennsylvania Counties. The directive requested that the recipient ascertain the need for increased mental health services in the Pennsylvania Counties.

The recipient would reach out to all mental health-funded subrecipients to identify gaps in services such as a waiting list. The recipient stated that there does not appear to be an increased need reported directly to the recipient through additional funds requests or technical assistance. A. Edelstein asked if the previous sentence had stated that the level of services was meeting the need. A. McCann-Woods said this was correct.

After reviewing the Pennsylvania County directives, A. Edelstein reviewed the directives from Philadelphia County. The first directive requested that the recipient review which services were most utilized and needed by PLWH 50+ years old. The directive wanted the recipient to encourage outreach to said population to ensure HIPC was informed about funded services.

The recipient answered the directive by stating that services most utilized by PLWH 50+ years old would require further research via study of the recipient's databases and direct inquiry with subrecipients. The recipient said this process would take time, but they were aiming to provide accurate information before the close of the fiscal year which would end on February 29th, 2024.

The recipient said much work had already taken place. The recipient convened a community-led symposium called Aging and Thriving which took place May 24th, 2023. The recipient described the symposium as a day of discussion and resource-sharing for adults with HIV over 50 and their service partners. It was attended by 83 in-person attendees and about 20 online participants throughout the day. The goals of the symposium were to foster dialogue between community members and providers of health and social services about the resilience, challenges, and wisdom of people aging with HIV. The second goal was to provide education to providers and community members about accessing services to meet the intersecting nature of health, economic, and service needs of people aging with HIV. The third goal was to provide insight to PDPH DHH on how to design services that best serve the diverse local community of individuals aging with HIV, and align services for aging populations with the local EHE plan.

Another symposium was tentatively planned for the third week of May 2024. The recipient would reconvene the planning committee for the symposium starting in December 2023. The University of Pennsylvania has been selected as the focus group provider for adults with HIV and they were currently in the development and Institutional Review Board (IRB) phases of the project.

The second directive from Philadelphia County requested an increase in access to and awareness of Food Bank services, especially those that were culturally relevant. Additionally, Philadelphia County requested more information on Food Bank services provided and their utilization to determine improved health outcomes. 5 subrecipients in Philadelphia receive RW Part A funding for food bank services. The range of food bank services included traditional food banks and food vouchers to various merchants. After reviewing these services, subrecipients were implementing culturally relevant and appropriate food bank services.

A. Edelstein then read the recipient's response to access to food bank services. Clients were given the option to choose which food items they would like to take home. This may look like "supermarket" style food bank access or clients can submit a food bank shopping list while the worker packs their food bags. These same providers may source food items from Philabundance, Amazon, BJs, etc. During the holiday season, many subrecipients would make available food baskets.

Clients were also given additional resources for food banks in and around the area, and agency brochures to make them aware of in-house services. Moreover, clients were assessed to ensure access to entitlements such as the Supplemental Nutrition Assistance Program Pennsylvania (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). A. McCann-Woods reminded the HIPC members that SNAP was also called food stamps.

Food voucher selection took into consideration the cultural needs and access limitations among clients. This included getting vouchers from local supermarkets and supermarket chains. Alongside cultural relevance, other accommodations were made such as language access, allergy consideration, food delivery, dietary considerations, supplements, and water filtration. At least 2 subrecipients have disclosed they have events or acknowledge cultural needs by having monthly Hispanic heritage pantry days. Additionally, the subrecipient shared that they have annual surveys specifically about their food bank services to ensure their needs were met. However, one subrecipient reported they need additional support to competently offer and address diverse diets such as religious considerations, vegan, and vegetarian diets.

A. Edelstein said there were additional questions from the CPC that they had forwarded to the recipient. The first question from the CPC members asked for a breakdown of spending for activities within Substance Use Services (outpatient), specifically looking at drug testing. The CPC wanted to know how money was allocated within this service and as much information as possible without identifying the organizations. The recipient replied that Ryan White funds did not pay for drug testing in this jurisdiction. All Ryan White Part A Substance Use Services funding in the Philadelphia EMA was used to onboard/retain licensed and certified counselors to provide individual and group counseling to eligible Ryan White Consumers.

The second question asked how transportation was being utilized. They asked if there was any way to receive a breakdown of SEPTA/public transportation versus ride shares versus personal provider vehicles. The recipient answered that currently, 5 subrecipients provided Medical Transportation Services for Ryan White eligible services, chiefly medical care, oral health, and medical case management. There were several modes of transportation utilized: agency vehicles, one-way SEPTA key cards, shared rides (uber/lyft), taxi services, and mileage reimbursement.

A further breakdown of how funds were utilized demonstrates approximately 49% of funding was utilized to pay for SEPTA key cards, shared rides, taxis, mileage reimbursement, and monthly county transportation service fees. The balance of funds was utilized for administration of the located transportation program coordination and supervisory staff, agency drivers, and operational expenses (communications, rent, insurance, etc.)

The third question from the CPC members asked for more details about mental health utilization within Philadelphia since there was recently increased spending and clients. The CPC members asked if the recipient had any recommendations or other information that could prove useful due to increased utilization. The recipient answered that Philadelphia County currently had 6 subrecipients who receive Ryan White Part A funding for Mental Health Services. This included 2 hospital sites, 3 federally qualified health centers, and 1 co-located wellness center. There was also a combination of traditional mental health services which included one-to-one counseling sessions and Behavioral Health Counseling (BHC). BHCs provided brief, short-term behavioral health counseling services to RW PLWH in the Philadelphia EMA. BHC services were typically provided by a psychologist, licensed clinical social worker, or other behavioral health professional as part of the health care team. The recipient said that BHC services positively contribute to improved health outcomes such as durable viral suppression and retention in care.

The recipient replied that coverage for all PWLH who receive mental health services was varied. Most RW-eligible clients were eligible for and utilized Medicaid. However, some clients also have personal/private (HMO) insurance and may also utilize the Special Pharmaceutical Benefits Program (SPBP). After reviewing data for FY22, the recipient broke down the information as follows: 51.3% of all RW clients had Medicaid, 22.3% had Medicare (4.2% unspecified, 18.1% Medicare Part A and B), 9.6% had no insurance, 12% had insurance through an employer, 3% had private insurance and 1 had other insurance that was not specified.

The recipient noted that FY22 data demonstrated the average number of visits per client was approximately 3. 59% had at least one visit. 37% had at least 2 visits and 5% had 12 or more visits. The recipient said further research was required to learn the proportion of clients who were receiving in-person and telehealth services. However, telehealth services were available at all RW service sites.

The recipient commented on increased utilization. They said one subrecipient had requested over the past 2 funding cycles to offer mental health services instead of their typically funded substance abuse services. At their site, substance abuse services were grossly under-utilized. The recipient agreed to this plan. The recipient then made the recommendation to reallocate funds to ensure mental health services were rendered at this site permanently. Additionally, increased utilization indicated an increased need. Despite this, the recipient stated that subrecipients had not requested additional funding.

A. Edelstein said the information presented was gathered by A. McCann-Woods after much discussion with other DHH staff members. He thanked her for going through a great effort to inform the HIPC members. A. McCann-Woods said that all statements that indicated that the recipient would up or investigate further would be completed before the end of the contract period on February 29th, 2024. She said certain information was more difficult to obtain than others and she thanked the HIPC members for their patience.

Committee Reports:
-Executive Committee-
None.

-Finance Committee-
None.

-Nominations Committee-
M. Cappuccilli said they had been reviewing applicants over the last month. 23 applicants were approved and sent to the Mayor and the committee was awaiting official letters of appointment. He then welcomed the new members to join the Nominations Committee meetings and said the total membership was now 42 people. 31% were unaligned consumers and 36% were PLWH.

He said the challenge they were facing was finding more representation from Philadelphia suburbs and New Jersey Counties. He said they could use at least 2 more members from each of those regions.

M. Cappuccilli said that had met earlier and discussed the orientation meeting presentation and other materials. He said the orientation date was tentatively planned for January 2024. He said they would communicate more information soon.

-Positive Committee-
K. Carter welcomed the new members. K. Carter reported they had their first in-person meeting on October 9th. He said there were only two members in attendance including himself. He said they discussed aging with HIV and how they could transition from a primary care provider to a geriatric care provider. He said they had also discussed mental health issues concerning older PLWH. K. Carter said they discussed topics such as housing, security, and isolation. He said they had also discussed how they could preserve independence for older PLWH. They also talked about how they could provide home services for older PLWH.

He reminded the HIPC membership that the Positive Committee met on the second Monday of every month. He said the next meeting would be virtual and encouraged members to attend. K. Carter ended his report by announcing that S. Moletteri had a monthly newsletter and encouraged all to read it.

-Comprehensive Planning Committee-
D. D'Alessandro said she could not find the minutes from the last meeting. She said she did not have a recollection of the meeting. S. Moletteri said the minutes were not uploaded to the website until they were approved by its respective council/committee.

S. Moletteri said in the last CPC meeting, the members discussed the questions forwarded to the recipient. They would review the responses at the next meeting.

A. Williams said he had received an email from M. Ross-Russell informing him that Dr. Brady would answer questions from the last HIPC meeting that were not answered.

-Prevention Committee-
D. Surplus announced that they were still looking for a co-chair to replace C. Steib at the Prevention Committee.

T. Dominique said the Prevention Committee would have a combined meeting next week due to the holidays.

Other Business:
None.

Announcements:
E. Torres introduced herself as part of Action Wellness and a new member of HIPC. She said she was happy to join the group to do important work. The HIPC members greeted her in return and congratulated her.

D. D'Alessandro said the city issued a health advisory called Shigella, a bacterial infection caused by lack of hygiene. She said it was spreading among those who were PWID and those who had housing insecurity. She advised the HIPC members to wash their hands. She said if a provider would meet a person from these vulnerable populations, they could forward information from the health advisory for safe practices.

M. Woods announced an ice cream social on November 25th from 3 pm to 5 pm at the Dorothy D. Allen Community Center in South Philadelphia for those who were ages 14 and up. M. Woods included the registration link in the chat and encouraged the members to reach out if they had questions.

S. Johnson announced there was a safe injection discussion on Monday at the South Philadelphia Library. He then provided a link to the event in the chat.

A. Thomas-Ferraioli announced that there was a World AIDS Flag Raising Day at the Municipal Services Building on December 1st. S. Heaven asked if the event would be held at 3 pm. A. Thomas-Ferraioli replied that the time was to be determined until they had confirmation from their city partners. She said it would be indoors and they were targeting an 11 am to 12 pm time.

Adjournment:
S. Heaven called for a motion to adjourn. **Motion:** K. Carter motioned and D. D'Alessandro seconded to adjourn the October 2023 HIV Integrated Planning Council meeting. **Motion passed:** All in favor. The meeting adjourned at 3:47 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:
- November 2023 Agenda
- October 2023 Meeting Minutes