Meeting Agenda

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

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(April 14, 2021)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - COVID-19 Survey Update
    - Integrated Plan Update
- Action Items
    - Recommendations from April CPC Meeting
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next Comprehensive Planning Committee meeting is
VIRTUAL: June 17, 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, April 15, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Ebony Boswell, Allison Byrd, Keith Carter, Debra D'Alessandro, Dave Gana, Pamela Gorman, Gus Grannan, Marilyn Martinez, Nicole Swinson

Guests: Jessica Browne (AACO)

Staff: 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 introduced himself and asked everyone else to provide their name, area of representation, and plans for the weekend.

Approval of Agenda: G. Grannan referred to the April 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, D. D'Alessandro seconded to approve the April 2021 CPC agenda. **Motion passed:** 67% in favor, 33% abstaining. The April 2021 CPC agenda was approved.

Approval of Minutes: (*March 18, 2020*) G. Grannan referred to the March 2021 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the March 2021 minutes. **Motion**: K. Carter motioned, D. D'Alessandro seconded to approve the March 18, 2021 meeting minutes. **Motion passed:** 67% in favor, 33% abstaining. The March 2021 CPC minutes were approved.

Report of Chair:

G. Grannan reported that there was currently only one CPC co-chair. This would be the first item they would address on the agenda. He asked that they brainstorm HIPC members that would be a good fit for the position.

Report of Staff:

S. Moletteri reported that the Ad-Hoc Recruitment Workgroup met yesterday for the first time. They discussed goals, action steps, and timeline for their recruitment plan. When discussing goals, the group discussed recruitment materials and identified target populations. The next Ad-Hoc Recruitment Workgroup meeting would be on May 5th at 2:00 p.m.

Action Items:

—Co-Chair Elections—

G. Grannan asked if there were any nominations for CPC co-chair. He asked if staff could go over the terms and roles for the position. M. Ross-Russell explained that the main role of co-chair was to facilitate meetings. In order to minimize the appearance of inappropriate or improper decision-making, the co-chair minimally engaged in overall discussions to move a conversation along. The co-chair, therefore, sometimes lost their voice in the process.

Additionally, M. Ross-Russell noted that the co-chair abstained from voting on various items, such as action items. When they did vote on action items, it was to break a tie. Co-chairs also worked with OHP staff on the agenda, etc. S. Moletteri added that the co-chair position was a two-year term. M. Ross-Russell said that most co-chairs participated for longer than two years if they chose to do so.

S. Moletteri explained that having two co-chairs was beneficial because they could share the work. Furthermore, if one co-chair was not able to attend the meeting, they had backup. G. Grannan added that the co-chairs were on scattered terms so both co-chairs were not up for election or reelection simultaneously. G. Grannan said he was on his first term year, and they would have another election for his spot the following year. He asked if anyone had other questions about the position or procedure.

K. Carter pointed out that there were no nominations for co-chair thus far. He suggested nominating D. D'Alessandro. D. D'Alessandro felt she was still new to the process and was only recently made a full member. She said she would like to go through a full cycle of being a participant first. She added that she understood the role of neutral facilitator but wanted to participate with strong opinions in her first year. This may help her build her experience and consider a position as co-chair in the future. She suggested J. Browne as a co-chair since she was from AACO and very familiar with data. She asked if it would be okay to nominate her for the position. J. Browne said she was under the impression that AACO did not serve as co-chairs on the subcommittees. G. Grannan agreed.

K. Carter asked to postpone the co-chair discussion for few months. M. Ross-Russell said they could do this. Ultimately, it was up to the committee on how they wanted to move forward with this.

K. Carter said that, traditionally, they nominate those who regularly attend the committee meeting for the position. He explained that, even those attending regularly, however, may be hesitant to take on the position. D. D'Alessandro agreed, noting that because HIPC was a volunteer group, taking on the extra responsibility may be a challenge. S. Moletteri said that in order to see individuals who regularly attended meetings, they could look at the CPC minutes on the website. G. Grannan suggested that it would be valuable to have someone who represented either PA or NJ counties as co-chair. Anyone who had that experience might want to consider the position to help him support the gaps in information since he worked for the city. M. Ross-Russell said that in the interim, they could reach out to members from the counties who were part

of CPC to see if they were interested in the co-chair position. K. Carter asked to nominate P. Gorman for the position since she represented the NJ counties. G. Grannan asked if he could chat with her directly to try to garner a response.

G. Grannan said that they could postpone the nominations. G. Grannan said that if there was anyone else they wanted to nominate, they could get in touch with staff. P. Gorman said that having a NJ county co-chair was a great idea, but she wanted to know more about the requirements for the position. K. Carter said that she could reach out to OHP staff for more information. G. Grannan told participants to contact OHP staff if they wanted to nominate themselves or others.

Discussion Items:

—Integrated Plan Section 2 Update—

M. Ross-Russell reported that regarding the Goals, Objectives, and Activities section of the Integrated Plan, they received the AETC information and updated the sections accordingly. Currently, they still did not have NJ and PA information on ADAP. She still needed to follow up about perinatal case management number with one indicator. As for ADAP information, they had about three or four data indicators that were still outstanding. The others had been resolved. Internally, OHP talked about moving to the next step to start working on the final document and brining closure to outstanding information.

Guidance for the next plan would come out at some point this year. For the sake of brevity, she wanted to ask if there were any questions, concerns, or issues with proceeding in this way. Nobody had any objections. G. Grannan thanked M. Ross-Russell for the update.

—Topics from March 2021—

S. Moletteri reviewed the handout from the March 2021 meeting. She organized the handout based on how the committee discussed approaching each of the topics. This was all based on the conversation around the Situational Analysis from the EHE plan. She reminded everyone that the Situational Analysis was specific to Philadelphia and currently in its implementation phase. The reason they reviewed the Situational Analysis was to see how they could expand it to the entire EMA. As they knew, she said, NHAS, EHE, and likely the Integrated Plan would and did have similar language and goals. S. Moletteri asked how they would like to review the worksheet and if the organization made sense to everyone. She gave everyone a second to read through everything and ask questions. If there were no questions, she would start from the beginning of the handout.

K. Carter said that extending provider hours had come up a lot, and he felt that this was a strong recommendation that they could make. He felt that extended hours worked well for retaining people in care. As “Immediate ART,” he said that once someone tested positive for HIV, having them walk out with medication right away would be the most effective approach. He said that this would help people give the confidence to start their medication and come back after their 14-day supply. He felt that the first two were recommendations that they should definitely make.

S. Moletteri asked if they wanted to work on wordsmithing language around the first two bullet points. K. Carter said they should talk more about their definition of extended hours. He felt that they needed to include Saturday hours for people working during the week. He suggested extending hours to Saturday with Saturday being open from 9:00 a.m. – 5:00 p.m. A. Byrd said that at her organization, they were having issues with people keeping their appointments on Saturday. She was unsure if this was due to COVID-19. N. Swinson agreed, noting that within her organization, for their extended provider hours, they still did not have a large amount of response.

K. Carter asked for more details around their extended hours. A. Byrd said they were open from 9:00a.m. – 4:00p.m. and Wednesdays from 9:00 a.m. – 8 p.m. Some days they stayed later—like 6:00 p.m.—for clients who requested it, but occasionally, the clients still missed the appointments.

K. Carter asked if they knew why clients were missing appointments. Did they have issues with transportation or childcare? N. Swinson felt it may have been the population they were serving and a multitude of factors. A. Byrd said her organization had Uber Health and other ways to provide transportation for clients.

M. Ross-Russell said that, historically, the problem with extended hours was often that many providers were not updating or advertising their extended hours. As OHP staff, they had difficulty with locating hours of availability and accessing other information when they were attempting to create and update their OHP resource inventory on the hivphilly website. She mentioned that the committee/council consistently discussed the digital divide and accessibility. She added that the director of AACO was currently looking into this subject matter to ensure services were available and clients had great accessibility. Sometimes, a lack of accurate information inhibited people's participation and retention in care. Extended hours would likely be a topic of conversation with longevity since it correlated with AACO's new client-centered approach. The idea of a client-centered approach meant that there was "no wrong door" for clients.

J. Browne said that M. Ross-Russell was correct and that AACO pinpointed extended hours and increased access to care as priorities. G. Grannan said that from his experience with service delivery, changing locations or hours may take a while to bear fruit. G. Grannan said that it may take six months to a year for people to start going to a new site or accessing extended hours. Providers may also have to work on building trust with their clients by making sure they are patient and available as a provider. G. Grannan said that within the city, there were a lot of social service agencies available only 9:00 a.m. – 5:00 p.m. He said that providers who did not see their changes make an impact should not yet lose faith. Just because they did not have "hard data" to support their changes did not mean what they were doing was not worth it.

A. Byrd said they had not given up hope, as they noticed that people were not keeping appointments as often because of COVID-19. P. Gorman asked whether extended hours would be for routine or sick visits. She also suggested that they should look into AACO's definition for Immediate ART.

D. D'Alessandro said that AACO had a definition. J. Browne said "immediate" was defined as within 96 hours. Last she heard, AACO "started the clock" as soon as a patient was diagnosed to help facilitate urgency. She had not yet heard follow-up around this.

K. Carter asked if someone took rapid test and tested positive, if they would start their medication that same day. J. Browne responded that she emailed S. Branca from AACO and would let them know if she got a response about Immediate ART before the meeting ended. K. Carter reiterated the importance of getting patients into treatment as quickly as possible.

D. D'Alessandro said that providers should now be well-versed in HIV testing and should be able to convey to newly diagnosed patients that living with HIV was manageable. She felt that this was a message of hope and that a 2021 diagnosis may hold a very different message than a diagnosis from a prior era. She said that providers practicing Immediate ART were reporting a lot of success.

J. Browne reported that S. Branca responded and said that the clock started for Immediate ART as soon as someone was diagnosed with HIV. It was preferable that a clinician prescribed ART right away to fulfill the proactive response they were looking for. G. Grannan knew of models, one of which involved prescribing PEP within 6 hours. He felt the timeframe for ART was doable.

K. Carter asked if they had a list of physicians they could contact to push Immediate ART. D. D'Alessandro asked if there was anybody in the current meeting that did testing but not prescribing. If so, she asked how they handled connecting patients to care to start ART. M. Martinez said her organization reached out and connected to another organization that had a prescriber. Her organization performed the rapid testing, and they referred them to the other organization for prescription of medication. D. D'Alessandro asked about the timeframe between referrals, and M. Martinez said they tried to get an appointment with the other organization within 30 days or ASAP. If they could make the referral right away, that was ideal. She said that they were open Monday-Saturday to ensure the patient was engaged ASAP.

N. Swinson said that her organization performed testing and was recently trying to achieve 72-hours ART. They were forming MOUs with places closer to her organization so that they could help achieve this. P. Gorman said that in NJ, they had MOAs with CTR sites and agreed to receive patients at medical care sites within 24-72 hours.

M. Ross-Russell asked what they would like OHP to do with this information. M. Ross-Russell said that the new Integrated Plan was on horizon and would likely be a combination of NHAS and EHE. They were also working on finalizing the current Integrated Plan and anticipating allocations. She said it would be beneficial for HIPC to support next steps or language around extended hours and Immediate ART if they felt strongly about this. She asked if they would like OHP to wordsmith with the two recommendations. Additionally, if CPC decided to go with the language, she asked where the language would go: recommendations/next steps for the Situational EMA-Wide Analysis, recommendations/directives for Allocations, and/or the next Integrated Plan?

M. Ross-Russell said that once they concluded their decisions as a committee, it would go to the full Planning Body for input. G. Grannan said when presenting to the full council, it would go to an immediate vote since it was coming as a recommendation from CPC.

K. Carter said that since allocations was coming up, he felt they could suggest the two during the allocations process. He felt that this would work best. G. Grannan asked if these three options were mutually exclusive. M. Ross-Russell said that they were not, and CPC could choose to incorporate the two topics into all three suggestions.

P. Gorman said that they should expand on their recommendations for each of the topics such as: what are we asking to occur for expanded hours and how are we defining Immediate ART? She asked if these points be included as part of the funded service categories. M. Ross-Russell agreed that there were particular things that could be expanded upon as per P. Gorman's comment. The other thing, she said, was that EHE was a new component which would be incorporated within Integrated Plan discussions and decision making. She asked if they also wanted to include the two points about extended hours and Immediate ART in Integrated Plan language.

K. Carter asked to clarify and define these two topics before they continued forward with the rest of the handout. M. Ross-Russell said that OHP could work on the language, work with the recipient on the language, and bring it back CPC for further discussion. It could go to HIPC likely in June 2021. G. Grannan asked if anyone wanted to make a motion to have staff work on the language for the two points and bring the product back to CPC. **Motion:** K. Carter motioned for OHP staff to work on recommendation language for extended hours and Immediate ART to bring back to CPC for approval, A. Byrd seconded. **Motion passed:** all in favor.

S. Moletteri asked for clarification around extended hours for accessing care, especially considering comments about weekend hours earlier in the discussion. She explained that P. Gorman mentioned that they should discuss more about what extended hours meant. M. Ross-Russell said that there were official provider definitions for extended provider hours, which outlined extended hours as being during the weekend and at least one weekday evening. They could pull the official language to help guide the directives.

G. Grannan moved along on the worksheet, looking at the section "Possible Policy Advocacy." He read the first item, "the integration of Behavioral Health and Primary Medical Care" with the subhead "similar to the 'One-Stop-Shop Model.'" M. Ross-Russell asked if this model was similar to that of the Medical Homes Model. P. Gorman responded yes. G. Grannan said that from his perspective, this sounded like organizations trying to become FQHCs with more integration of services. K. Carter asked for more clarity behind the Medical Homes Model. M. Ross-Russell said that it was similar to the One-Stop-Shop Model and worked to ensure that Behavioral Health was integrated into Primary Medical Care with a medical team to support it.

P. Gorman said the Medical Homes Model involved a certification process—however there were also RW funded agencies that were one-stop-shops, mirroring the patient-centered Medical Homes Model.

K. Carter asked how many organizations had these models. M. Martinez said there were a few in Philadelphia that had this model. Her organization had individuals who were certified and they were a total Home Care Center Model. Her organization had been in the community for 51 years. She said they had many locations throughout Philly. She believed there were other FQHCs who also had this kind of model or fragmented versions of the model. P. Gorman said that many FQHCs were certified as PCMH and that there were different levels of certification. She said that the primary goal was demonstrating high quality medical care services through performance measures.

G. Grannan said that along with M. Martinez's organization, a lot of agencies were aiming at this sort of model, even if they did not fulfill every definition of the category. G. Grannan said they would likely see more organizations following this model since it was so effective. M. Martinez agreed, saying that data supported a total health care model, showing more adherence and compliance to care. Patients were more likely to be healthier as people and happier with their services. She explained that navigating the healthcare system could be a challenge, so having everything in one place would help people adhere to care.

G. Grannan asked how involved HIPC could be with policy advocacy. He asked if CPC had to work more separately from OHP and AACO for the policy advocacy issue. M. Ross-Russell said that the Planning Council could openly state that they supported the idea of one-stop-shops and similar models. They could also advocate for this privately. M. Ross-Russell noted that there was one county within the EMA that had no FQHCs. G. Grannan asked if it was Salem County, and M. Ross-Russell responded that it might be Bucks County. D. D'Alessandro and K. Carter agreed, saying that it was likely Bucks County.

G. Grannan said that all of the topics mentioned could be looked at in a way that could lower barriers to services. This could be viewed as an overarching goal for the council, AACO, and AACO's subcontractors. G. Grannan said that staff could address this in the same way and bring this back to CPC as well.

G. Grannan looked at the "Request for More Information section," He noted that both requests involved mental health. M. Ross-Russell said that staff could work on requests for information.

G. Grannan read the rest of the handout. K. Carter asked if they could look into child-care within providers locations. M. Martinez suggested they do. D. D'Alessandro said that because of the COVID-19 response, patients could not bring children with them, even in the waiting room. M. Martinez agreed that patients and guardians were now having difficulty due to the COVID-19 restrictions.

G. Grannan said that while guardians could get vaccinated, people under 18 were having difficulty accessing vaccinations. M. Martinez said that Pfizer approved the vaccine for those who were 16 years and older. Pfizer started a trial for those who were younger but did not yet have a full understanding.

K. Carter asked if childcare came out of RW dollars. M. Martinez said that before COVID-19, they had playroom areas for children to be with their parent or guardian. The children would then

join the parent or guardian for their appointment. Exam rooms would accommodate the child and adult. With the COVID-19 response, she explained, they discouraged kids to parents or guardians in their appointments and vice versa.

K. Carter asked about home visits to help with the childcare aspect. M. Martinez said her organization was considering home visits before COVID-19, and in 2019, they stopped looking at those opportunities when COVID-19 hit. D. D'Alessandro said that there were adherence checks with pharmacies where they would send a nurse to a house to help patients fill their pill boxes. K. Carter said going to patient's home would likely help with treatment and help create a better personal connection and receive fuller care.

G. Grannan next looked at the "Stable Housing" and "Transportation" topics. He said these two became more challenging, along with childcare, due to the COVID-19 pandemic. K. Carter said that transportation was difficult given the current provider. He suggested looking into other providers for transportation. A. Byrd said that once the moratorium ended, they would have a lot of issues with evictions. K. Carter asked about the rent relief programs such as the CARES money that would assist with rent. He mentioned how the dollars were underutilized A. Byrd said a lot of evictions were occurring because landlords were not paying taxes and using the moratorium as an excuse. S. Moletteri provided a link for rental assistance funding streams within Philadelphia. G. Grannan said that, within the city, evictions now depended on the landlord making an application to resolve unpaid rent without an eviction.

A. Byrd said that she knew of places taking PLWH who were now unhoused in Delaware and Baltimore. The one in Baltimore, she said, was called Project PLASE. M. Martinez said she was having a similar issue with rent, and M. Ross-Russell said that there was the Shallow Rent Program (on the resources page on the hivphilly website). She said that Philadelphia also was paying for backrent in some instances in their Rental Assistance Phase 4. S. Moletteri said that Phase 4 information was also on the resources page.

Other Business:

None.

Announcements:

J. Henrikson announced that she received an email M. Coleman about a Philly FIGHT training. The training was on Thursday, April 22nd from 12:00-1:30 p.m. M. Martinez said she was using this training for her staff.

D. D'Alessandro announced that there was a Xylazine training later this month. Xylazine was an animal tranquilizer found in recreational drugs as of late. D. D'Alessandro said that there was no easy way for toxicology screens to pick it up. She provided the link for the training in the chat as well as the training details. The training would be on Tuesday, April 27 from 10:00 a.m.-12:00 p.m. G. Grannan said that Ketamine and Xylazine were commonly used in veterinary processes. D. D'Alessandro said they had a limit of 500 registrants and were providing credits.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the April 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 4:13 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- April 2021 CPC Meeting Agenda
- March 2021 CPC Meeting Minutes
- Topics from the March 2021 CPC Meeting for the April 15, 2021

Recommendations from April 15, 2021
Comprehensive Planning Committee
May 20, 2021

Directives (language borrowed from EHE, Pillar 2: Treat):

1. In accordance to federal treatment guidelines, increase access to immediate ART initiation (within 96 hours).

2. Expand operating hours to include evening and weekend appointments for HIV medical care in community and hospital-based HIV treatment sites.

Goal for Planning Council:

- As a goal, HIPC would like to lower barriers to care to create a client-centered care system by: implementing immediate ART, expanding operating hours, and openly supporting the integration of services through One-Stop-Shop and similar models.