Philadelphia HIV Integrated Planning Council
VIRTUAL: Comprehensive Planning Committee
Meeting Minutes of
Thursday, May 20, 2021
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Debra D'Alessandro, David Gana, Pamela Gorman, Gus Grannan (Co-Chair), Nicole Swinson, Evan Thornburg, Adam Williams

Excused: Allison Byrd, Gerry Keys

Guests: Julia Scarlett (AACO), Tonya Cooper

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

Call to Order/Introductions: G. Grannan called the meeting to order at 2:08 p.m. He asked everyone to introduce themselves with their name and area of representation.

Approval of Agenda: G. Grannan referred to the May 2021 CPC agenda S. Moletteri distributed via email and asked for a motion to approve. **Motion:** K. Carter motioned, D. Gana seconded to approve the April 2021 CPC agenda. **Motion passed:** 86% in favor, 14% abstaining. The May 2021 CPC agenda was approved.

Approval of Minutes: (*April 15, 2020*) G. Grannan referred to the April 2021 CPC meeting minutes S. Moletteri distributed via email. G. Grannan called for a motion to approve the April 2021 minutes. **Motion**: K. Carter motioned, D. Gana seconded to approve the April 15, 2021 meeting minutes. **Motion passed:** 88% in favor, 13% abstaining. The April 2021 CPC minutes were approved.

K. Carter suggested that within the meeting minutes, acronyms be defined. There could be a cheat sheet included within the meeting minutes or they are defined at first mention. S. Moletteri responded that there was a cheat sheet of acronyms on the website. She asked if the cheat sheet would be helpful to include on the minutes page or how he suggested the cheat sheet be presented. K. Carter responded that mentioning them within the minutes would be best.

Report of Chair:

No report.

Report of Staff:

M. Ross-Russell reported that the Site Visit information first went through Finance Committee. There were two areas that OHP (Office of HIV Planning)/HIPC (HIV Integrated Planning Council) were cited as part of the Site Visit. They were cited on Monitoring the Admin Mechanism for Rapid Distribution of Funds which was generally overseen by Finance

Committee. They were also cited for HIPC's review of the OHP/PC support budget. Both were currently being addressed within Finance Committee. Finance Committee was to review the budget in their June 2021 meeting. Additionally Finance was working on a form for Monitoring the Administrative Mechanism that could be reviewed and submitted annually.

M. Ross-Russell reported that they would discuss the allocations process for July 2021 during their June 2021 meeting.

S. Moletteri reported that the Ad-Hoc Recruitment Workgroup email had been sent out to the full council. The email noted that the next meeting date was undecided and offered a poll for interested attendees to check off their preferred meeting date.

S. Moletteri also reported that the resources tab included a Google Translate tab. This would allow people visiting the website to choose whatever language they needed—this was done through Google Translate. There was a link that directly translated to Spanish, and there was another link that allowed people to choose whatever language they preferred.

Discussion Items:

—COVID-19 Survey Update—

M. Ross-Russell said that in early 2021, N. Johns provided the committee with a summary report of the COVID-19 survey based on the initial online results (49 responses). Recently, OHP received an additional 36 hard-copy responses in the mail. The delay in receiving the responses was likely due to the lag in USPS services. All of the paper surveys were entered into Survey Monkey and the analysis was rerun which added up to 85 responses total. Realistically, this did not change the methodology, nor did it change the limitations.

Results made clear that respondents' income were within a broad range. Most individuals participating online had access to the internet, which may have impacted participation and results. A mainly online survey meant that those who were not able to access a hard-copy survey or did not have online access were not reached.

When reviewing the survey results, the demographics for participants had a larger age range than the demographics of PLWH (People Living with HIV) within the Philadelphia EMA (Eligible Metropolitan Area). M. Ross-Russell reported on the age breakdown: 1 respondent was between 18-24, 10% of respondents were 25-34, 13% were 35-44, and 33% were 45-54. The remaining respondents (45%) were older than 54 years old.

Respondents by breakdown of race/ethnicity was not completely representative of PLWH within the EMA. A little over half of respondents were AA (African America)/Black, and about a third of respondents were white. The rest of the demographic information was suppressed in the reporting due to the small percentages.

Most respondents had received a COVID-19 test. Income-wise, there was a larger percentage of those with a higher income than those who are typically served through RW (Ryan White) within the EMA.

By in large, most respondents reported that they did not miss their medical appointments. For those who did, they identified barriers around food, housing, and concerns with rent and mortgage. Some individuals noted issues with transportation services, but many respondents were electing not to use public transportation.

Some answers, she noted, changed with the addition of the paper surveys. For example, there were changes in the responses for well-being which asked people about sleeping habits, anxiety, depression, hopefulness/hopelessness. More respondents reported trouble falling asleep which averaged out to the same number of individuals who felt hopeful. The percentage of people who felt nervous decreased and was initially 70% with the smaller sample.

M. Ross-Russell highlighted the table which broke down the responses by demographics. There were not major shifts between the last time they reviewed the survey and the responses now.

K. Carter noted that the number of people over 50 responded most. He suggested that in the future, they look into how service organizations were distributing the surveys and information in general. HE explained that there were many more PLWH in the EMA, so they should have received more participation. M. Ross-Russell responded that, at the time, there was an email that went from C. Terrell's office to providers and case managers to announce the survey.

What had become clear, M. Ross-Russell noted, was that the online surveys for OHP did not generate the number of responses they had hoped. This outcome for online surveys was common, as response rates tended to be lower. When distributing the Consumer Survey in the future, HIPC/OHP needed to review best methods for distribution. For their last consumer survey, they received 384 responses. When the survey was mail-out they received around 700 responses. They had to investigate this and see if individuals were reticent to respond online.

K. Carter asked about the literacy rate for PLWH within the EMA. A. Williams asked if they could offer compensation for participation in the survey. M. Ross-Russell responded that this depended on the process. This time around, surveys were anonymous and HIPC was working with provider sites. For the consumer survey, they provided packets that were distributed to provider sites who would give them to their clients living with HIV. OHP needed to review which incentives were affordable to be included in 3,000+ surveys. The offer of incentives was also linked to people's participation within focus groups. Focus groups were logistically better for providing incentives to those participating in the information-gathering process. The reason this was a challenge for the survey, itself, was because they had to track incentives which proved challenging due to the amount of surveys distributed.

D. Gana asked if the surveys defined the importance, e.g. they helped define funding, in the description. M. Ross-Russell responded that the surveys included information on its importance and the reasoning behind the questions. She said that the COVID-19 survey contained an

explanation as well. D. Gana asked if the explanation was online or just in paper. M. Ross-Russell said that the format was the same on both.

J. Henrikson screenshared the COVID-19 survey. M. Ross-Russell highlighted the section thanking respondents for participating and the short paragraph indicating the purpose of the survey. The paragraph also mentioned security and confidentiality of responses, length of the survey, and its voluntary nature. The survey was also available in Spanish.

K. Carter asked if OHP had ever used interns to be placed within waiting rooms at provider locations to distribute the surveys. M. Ross-Russell said they had with the PLWH survey that was administered every 4-5 years. The first few times they distributed the surveys, HIPC and Poz Committee members volunteered to work with provider sites to assist with the survey. However, this was not done with the online survey.

As a way to advertise, M. Ross-Russell explained that they sent out the information to provider sites and asked them to post it in their office spaces. However, the PLWH survey was long and time consuming. This is why they sent it out via mail as opposed to having people fill it out on the spot (whether it be in paper format or through a tablet). In-person efforts depended on the survey tool and length of the survey. Additionally, it depended on whether providers agreed to allow OHP and HIPC members on-site.

K. Carter asked if there was compensation for filling surveys out on-site. If this were the case, administering and tracking compensation would be simpler. M. Ross-Russell noted that a $10 gift card for 2,000 respondents added up. M. Ross-Russell said that for incentivizing participation, there was a limit to the number of people that they could compensate. In the case of an anonymous survey, signing off on a gift card was also mildly problematic. Additionally, asking someone to discuss barriers to services and experiences *at* a provider site was difficult. The location might add to a hesitancy to disclose information as they were waiting for their appointment. K. Carter agreed that it might be intimidating and difficult for the respondent. K. Carter suggested working towards making people feel more comfortable with being honest with how they felt about their services and ensuring them that there were no consequence with voicing concerns. M. Ross-Russell agreed, saying they could discuss this further, especially during their future needs assessment process.

As for the COVID-19 survey, M. Ross-Russell explained that they were looking for the impact COVID-19 had on individuals services and wellbeing. She noted that responses were similar to findings from throughout the year, pandemic or not. In other words, those within the lower income bracket had concerns regardless. Ongoing barriers/concerns included housing, transportation, and food insecurity. Mental health was also a concern for some.

M. Ross-Russell said that given the income drop-off for some individuals not working, they expected more comments around housing and other ancillary services, but this was not necessarily the case. K. Carter mentioned both the moratorium and rental assistance, commenting on how this might change the results.

A. Williams suggested a prize to the Case Manager that could distribute and return the most completed surveys. Additionally, he asked if it was possible that individuals with unstable housing were least likely to have capacity to complete the survey. M. Ross-Russell said it was likely that those with unstable housing were less likely to respond. She also noted that the digital divide impacted who was able to respond. This is why OHP administered as many paper surveys as they could. On the other end, it required that providers handed out surveys, though many providers were still working through telehealth.

G. Grannan asked about the timeframe for survey-return and if OHP was expecting to receive more. M. Ross-Russell said she had not completely closed the survey, but she had not received more since. The surveys were originally distributed in October 2020 and closed in January 2021. They received additional responses in March 2021.

D. D'Alessandro noted that many providers collected email addresses from patients to help them with their online health portals. Providers, in turn, were likely able to email the survey to their clients. M. Ross-Russell explained that OHP sent survey links to provider sites and through the Case Management listserv from AACO. They did this because of the many moving parts with virtual work. She agreed that they would have to consider multiple formats to submit and distribute information. G. Grannan pointed out that they should use as many media outlets as possible. However, he noted that some individuals rarely checked their email or offered an email they only used for spam/junk mail.

K. Carter mentioned how some might not trust the mail system and how they needed to consider this. M. Ross-Russell said that in the end, they would try their best to take into consideration the limitations and barriers for each method of contact and distribution.

—Integrated Plan Update—

M. Ross-Russell reported that the Integrated Plan data indicators had been updated, though she had not received responses for two areas. The document now needed to be brought to closure. OHP wanted to receive input from the committee on how to go about this.

She explained that the document needed to include plan, process, and conclusion, pointing out the changes in the 5-year Integrated Plan. EHE and implementation of EHE was a change which occurred during the Integrated Plan cycle. Additionally, they also experienced the COVID-19 response. OHP had to include/note such factors in the conclusion without starting a new discussion about the plan. There would be new guidance for the Integrated Plan coming out, so they were working to conclude and bring closure to the plan, not rewrite it. K. Carter agreed.

M. Ross-Russell said that as they reviewed the various sections, they will bring the components to CPC with comments and changes. Then, they would move onto the next section until they completed the plan. G. Grannan said this was doable and that they could deal with bits of it at a time if everyone agreed.

M. Ross-Russell noted that the original document was on the website and included the various updates. She asked how CPC wanted to receive the plan updates. G. Grannan suggested included

an annotated bibliography with the additional changes. G. Grannan asked if there were any more comments. There were none.

Action Items:

—Recommendations from April CPC Meeting—

G. Grannan moved onto the next action item. J. Henrikson screenshared the recommendations mentioned from the April 2021 CPC meeting. S. Moletteri introduced the worksheet, noting that last month they reviewed a worksheet that consolidated important themes from past discussions. These were the two directives that everyone motioned for staff OHP to wordsmith and bring back to CPC. In turn, CPC would vote on these and decide whether they wanted to bring these back to HIPC. She said that the language was directly from EHE (Ending the HIV Epidemic Plan) Pillar 2: Treat, so that there was consistency with language and no contradictions.

She read the two recommendations, noting that they would decide if they liked the language and how they would like it to be presented as a directive. For example, would they want this to be Philadelphia-based, EMA-Wide, etc.? They would want to specify this when bringing it to HIPC. She reminded everyone that EHE was Philadelphia-specific.

K. Carter said that the Immediate ART (Antiretroviral Therapy) recommendation needed more information, included what was in the starter pack. He recognized that there were no requirements for the starter pack, so this might be important to outline. Additionally, he felt that 96 hours was too long of a gap time, suggesting no longer than 36 hours. He felt that people should receive the starter pack right away, adding that the starter pack lasted 14 days. G. Grannan noted that the Immediate ART guidelines of 96 hours fell outside the guidelines for PEP (Post-Exposure Prophylaxis). D. Gana said PEP was 72 hours.

Overall, G. Grannan agreed with K. Carter, saying that they needed to talk with providers to look into their capacity and see what kind of support they needed to engage in Immediate ART. G. Grannan asked S. Moletteri if the 96 hours was coming from EHE. S. Moletteri responded that this was directly from EHE.

A. Williams noted that PEP and Immediate ART initiation were not comparable. PEP, he highlighted, was by necessity and as soon as possible to prevent infection that had not yet occurred. PEP was prescribed in high doses and known to have secondary side effects. For Immediate ART, this did not have to be the case, and the provider and patient could come together and choose the prescription that was best for the patient's health. He felt it was important to wait for lab results to come back and that 96 hours for initiation sounded fair. K. Carter said that people who tested positive did not need initial labs to receive ART immediately.

G. Grannan asked if Immediate ART without lab results would constrain the type of treatment a patient would ultimately receive. A. Williams responded that he was not a medical provider. However, he knew that providers needed lab results to surmise the best medication for patients' bodies. P. Gorman noted that patients could receive Immediate ART, but they should still have labs done and wait for the results. Patients could safely start ART, but the regiment they were

starting on might not be as effective. The three-drug regiment was potent, but if a patient had resistance to one or two, the provider might be exposing the patient to developing resistance to the third. This, of course, depended on how quickly the patient returned after receiving Immediate ART. She disclosed that she worked at Cooper, saying that they recently developed a policy for Immediate ART. Additionally, many agencies were still participating in clinical trials (enrolling clients in clinical trials was a RW-required activity where the patient is typically naïve to therapy), and this sometimes prevented providers from providing Immediate ART. Ultimately, she said Immediate ART was possible but that providers should still be drawing labs at the first visit. An exception to this, however, was if the patient came through ED (Emergency Department).

K. Carter noted that there were also concerns for those who were starting ART and pregnant. P. Gorman noted that there were medications that could safely allow for this. For the most part, it was older regiments that caused concern for ART and pregnant people. New regiments were mostly safe for those who were pregnant. Additionally, if someone who was pregnant came in was seeking treatment for HIV, the provider would likely refer them to the High Risk Pregnancy Program. K. Carter said he would send the Rapid-ART file from HRSA to OHP staff.

K. Carter mentioned the importance of differentiating between ART and PEP. He added that some providers did not know enough about ART and could be unhelpful to patients. G. Grannan added that providers would often wait to administer ART until they determined what strain of HIV the patient had. D. D'Alessandro noted that the guidelines for ART had changed in 2020.

A. Williams mentioned that the EHE Pillar 2: Treat language which was borrowed for the directives, did not include PEP. At the moment, they were discussing treatment, and PEP was under the prevention category. G. Grannan felt that PEP was prevention delivered through treatment mechanisms. Because of this, they needed to consider prevention that relied on treatment mechanisms. A. Williams agreed—however, the language on the recommendation from April 2021 discussed directives from Pillar 2: Treat, but PEP did not fall under Pillar 2: Treat. PEP was included within EHE, but it was within a different section. G. Grannan said they might need to rely on Pillar 3 to tackle this better.

D. D'Alessandro noted the following concern around the 96 hours for Immediate ART: a provider who received a positive result on a Friday. She said they would have to specify that this meant business days. Grannan agreed that 96 hours almost guaranteed an intervening weekend. K. Carter said that providers should not offer diagnoses on Fridays. G. Grannan said that there were a spectrum of reactions, and they had to plan for all cases.

J. Henrikson asked if they were considering changing the language. K. Carter said they needed a definitive answer for Immediate ART: how many days they were allowed to offer, what starter packs looked like, etc. P. Gorman said that providers likely had preference on what they wanted to start the patient on. This also depended on clinic's resources and what treatments they had available. As for timeline, she suggested they not deviate from the federal/EHE guidance since this is what most providers would refer to. A. Williams said they also had to consider insurance coverage. For example, individuals who were uninsured or uninsurable (e.g. undocumented

citizens), might have a very different experience with Immediate ART. Creating a specific mold might not be the most beneficial, since everyone's journey to care could be vastly different.

K. Carter agreed with A. Williams. He asked if, for people who were uninsured, how easily they could get on ADAP or SPBP. Specifically, could they do this in under 24 hours? P. Gorman said that this why the 96 hours might have been put in place—there were limitations during COVID-19 with access to ART through ADAP. She said that the wait period became more extensive, but she did not know what this would look like in the future. D. Gana noted that the wait time for SPBP approval was about two weeks according to AACO's reports. He said that it used to be 30 days.

K. Carter said that you should be able to get on SPBP within 24-48 hours if you offered all of the documentation needed, which was not much. A. Williams said this was true if they were willing to expedite it for SPBP, but this might not be the case for ADAP clients in NJ. K. Carter asked P. Gorman how long it took for clients to get RW certified in NJ Counties. P. Gorman said clients had to get recertified every six months, just like the PA Counties. As for the ADAP, she said, patients should get access to medication within 36 hours. They had challenges during COVID-19 where this got pushed to a week for waiting time on the application. She added that resources (personnel, time, effort) dedicated to HIV services got diverted to other areas because of COVID-19. Hopefully, this would change as COVID-19 was becoming more contained.

M. Ross-Russell noted that PEP was 24-96 hours, and Immediate ART was 96 hours or less. M. Ross-Russell said that 96 hours was the maximum amount of hours, meaning providers could not go over this amount. D. Gana and A. Williams agreed. M. Ross-Russell said that the reason they borrowed the EHE language was because this language was preexisting and consistent with the direction the recipient was already going.

M. Ross-Russell agreed that what they had discussed was notable and that staff was interpreting the conversations to help them navigate the direction in which they would like to go. K. Carter asked about the new guidance for Immediate ART. M. Ross-Russell said NIH was seven days which might be different from NHS guidance. She added that this information was from January 2020.

G. Grannan asked if they were okay with the language of the first two directives. He said that the second directive might be a longer discussion. P. Gorman noted that the second directive might be subjective and up for interpretation.

P. Gorman said that if they implemented the first directive, they add the resource for the 96 hour implementation. K. Carter agreed. G. Grannan said that this was a data point they would want to keep a close eye on. He asked if they receive ongoing information on the timeline for getting patients on ART, especially the cases that were 96 hours and over. Of course, going over the 96 hours would happen from time to time. This should not be punished, but he felt that CPC could examine the trends and look into how they could prevent lags.

M. Ross-Russell did not know if this could be implemented, but she would check. She was fairly sure that the recipient was monitoring this type of data, and hours for receiving ART had likely

become a data indicator. K. Carter asked if they knew other jurisdictions that were implementing Rapid ART. M. Ross-Russell did not know. They could reach out to other jurisdictions and find out what they were doing.

G. Grannan said that the more data they got on this, the better the outcome. K. Carter asked if places were already doing this, they could look at these models and either improve on them or use them as is. G. Grannan added that, if the AACO data showed that the Philadelphia EMA was doing well, they could offer technical support to other jurisdictions. Getting the hours as low as possible was an important goal—the EHE language of 96 hours, to them, should mean getting the hours as low as possible, not as close to 96 hours as possible. K. Carter said that there were likely providers who were already successfully implementing Immediate ART. G. Grannan said that with continuous quality improvement (CQI), this would be a reasonable, measurable outcome. As long as all of the clinical needs were being met, shortened hours for linkage to ART would be important.

M. Ross-Russell said that with CQI, it was a matter of finding out whether AACO had already implemented the use of data indicators for Immediate ART. To G. Grannan's point, she said that she would not be surprised if there was conversations amongst recipients and Planning Councils in other EMAs for best practices and information sharing around this topic. M. Ross-Russell said that OHP reached out on a fairly regular basis to review documents and review other EMA's processes to give the Philadelphia EMA ideas. Additionally, there were also Project Officers from HRSA that would ask EMAs to share information.

J. Scarlett noted that many of the EHE providers were in the infancy stage of implementation. They had an extensive evaluation plan, though she did not have details on frequency and data indicators. She could bring this information back to the council if needed. The implementation of Immediate ART was not yet far-reaching, but she would discuss this internally with AACO and share more information in the future.

G. Grannan asked to move into the operating hours directive. He felt that lack of operating hours was a large barrier within Philadelphia. As of right now, Philadelphia recommended that people not get tested on Fridays. He asked about plans around this line, J. Scarlett said that she could also look into this and report back.

G. Grannan asked if they wanted to vote on and give the directives to HIPC or if they wanted to wait on J. Scarlett's report back and adjust accordingly. He said that neither of the directives were currently being operationalized, but they could still gather data. If they decided to hold off on voting, he wanted to know why and what kind of timeline they were operating on. M. Ross-Russell suggested they wait to hear back next month from the recipient. In July, she said, they could review these for allocations. If the directives that were from the EHE language were still in their "infancy" phase, she said it might be beneficial to hear back from the recipient to adjust their own directives if needed. Within the allocations process, they could include the language as part of the directives process.

G. Grannan and D. D'Alessandro agreed. G. Grannan said that they could hold off on the last goal listed on the worksheet for HIPC until after allocations. He asked if everyone was okay with that as well. D. Gana agreed to postponing voting until next month. P. Gorman agreed.

Other Business:

None.

Announcements:

K. Carter announced that AID Education Month started in June 2021.

G. Grannan announced that June 2nd was International Whores Day. There would be a public presentation by a sex worker collective in McFurson Park in Kensington at 2:00 p.m. He encourage people to join.

A. Williams announced that June 5th was HIV Long-Term Survivors Awareness day, and June 27th was National HIV Testing Day. He asked if HIPC wanted to do anything for this. G. Grannan responded that the whole council should promote this, rather than the subcommittee, itself. He said that HIPC could choose to promote the awareness days, though he questioned how large their audience was. He suggested that they mention the awareness days at the general meeting even if it had passed. He imagined that AACO would have promotion out for June 27th. He asked if the office could promote this and have it ready for the general meeting. J. Henrikson said this was possible.

K. Carter said MNAC would be in Washington DC in a hybrid format. D. Gana said registration was open.

A. Williams asked about making a press release and promoting HIPC. M. Ross-Russell said that based on how their office was configured, all press releases had to go through the mayor's office which would slow down the process. K. Carter said that for the awareness days, they could go through the Office of LGBT Affairs. G. Grannan said they could also go through the Harm Reduction Office which was part of CBH (Community Behavioral Health).

Adjournment:

G. Grannan called for a motion to adjourn. **Motion**: D. Gana motioned, K. Carter seconded to adjourn the May 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 4:06 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- May 2021 CPC Meeting Agenda
- April 2021 CPC Meeting Minutes
- Recommendations from April 2021 CPC Meeting
- COVID-19 Survey Writeup