Prevention Committee
Meeting Minutes of
Wednesday, April 24th, 2024
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Clint Steib (Co-Chair), Jame Ealy, Gus Grannan, Keith Carter, Desiree Surplus (Co-Chair), Lorett Matus

Guest: Emily McNamara (DHH), Erin Kelly, Megan Reed, Brian Hernadez (DHH), Siegfried Aragona (DHH), Bill Pearson (DHH),

Excused: Kenneth Dillard-Cruz

Staff: Tiffany Dominique, Sofia Moletteri, Mari Ross-Russell, Kevin Trinh

Call to Order/Introductions: C. Steib asked everyone to introduce themselves and called the meeting to order at 2:35 p.m.

Approval of Agenda:
C. Steib referred to the April 2024 Prevention Committee agenda and asked for a motion to approve. **Motion:** G. Grannan motioned; D. Surplus seconded to approve the April Prevention Committee agenda via Zoom poll. **Motion passed:** 3 in favor, 1 abstained. The April 2024 agenda was approved.

Approval of Minutes (*March 27th, 2024*):
C. Steib referred to the March 2024 Prevention Committee Meeting minutes. **Motion:** K. Carter motioned; G. Grannan seconded to approve the March 2024 Prevention Committee meeting minutes via a Zoom poll. **Motion passed:** 4 in favor, 1 abstained. The March 2024 minutes were approved.

Report of Co-chairs
C. Steib reminded the committee about the upcoming Sex Med conference on May 3rd.

Report of Staff:
M. Ross-Russell reported that she had finished drafting the harm reduction letter after receiving input from various persons. She asked those HIPC members interested in signing to let her know.

S. Moletteri reminded the committee that the epidemiological infographics were uploaded to the Office of HIV Planning website and encouraged the members to read it.

Presentation:
-Substance Use Services in Philadelphia: Barriers and Facilitators to Access and Retention-

M. Reed and E. Kelly introduced themselves and their project to map the opioid use disorder treatment system in Philadelphia.

The presenter described the overdose crisis as occurring over 4 waves. The first wave started in the early 2000s with the overprescription of opioids. The second wave led to the rise of heroin use without stimulants in 2010. There was then a third wave with the rise of fentanyl use without stimulants without stimulants in 2013 and wave 4 with the use of fentanyl use with stimulants in 2015. To further her point, M. Reed presented a chart summarizing the number of deaths due to overdoses from 2010 to 2022. She remarked that the number of overdose deaths due to a combination of opioids and stimulants had increased from 127 deaths in 2010 to 777 deaths in 2022. She noted opioid overdose deaths without stimulants had decreased throughout the years from 529 deaths in 2017 to 394 deaths in 2022. M. Reed said this had implications for racial disparities. Using charts, M Reed showed that the Non-Hispanic (NH) Black population had more overdose deaths than the NH White population. Overdose deaths involving both opioids and stimulants were increasing for Hispanics, NH White individuals and NH Black individuals indicating a stimulant overdose crisis in addition to an opioid overdose crisis.

M. Reed said they had started their project because they felt that the Opioid Use Disorder (OSD) Treatment System in Philadelphia was not reaching the people who wanted or needed treatment. The study was a multimethod study that aimed to understand the status and capacity of the current OSD system using GIS mapping of treatment centers, focus groups, meetings with the community advisory board, and a methadone provider survey. They wanted to know how accessible services were, why someone would leave treatment early. and identify modifiable policy-related factors regarding treatment. Their end product was recommendations to the Department of Behavioral Health and Intellectual Disability.

For the next section of the presentation, M. Reed said she would review the qualitative results of their study while E. Kelly would review their mapping results.

The focus groups used in the studies were based on different factors such as whether they used methadone or buprenorphine. M. Reed said there were focus groups based on different identities such as parental status, pregnancy status, and race. About 61% of those interviewed had used a drug in the past month. 60% of those interviewed had overdosed at least once in their lifetime. 25% of the people in the focus groups had gone to an emergency room as part of their OUD treatment. 95% of those in the focus groups had been in some form of past-month treatment.

M. Reed reviewed the common themes they had found from the interviews. One common theme was that focus group members were frustrated by the assessment process. Many complained that they often had to wait as long as 18 hours before they were able to receive the treatment they sought. Those without homes experienced this with the added anxiety of insurance approval for the length of stay in treatment. Those who used buprenorphine and methadone complained about the daily requirements such as visiting the clinic daily for hours at a time. Location and transportation were commonly discussed issues. Reaching a location for treatment could be difficult for those who were unhoused or those who needed to use public transportation. For some, the location could trigger the urge to use drugs.

The study asked people who were Black or Hispanic about their experiences. M. Reed stated that people reported that there were language barriers to care as there was a lack of bilingual staff. This was a barrier to Spanish-speaking participants. In addition, focus group members reported instances of discrimination and the belief that some programs were more accessible to White participants.

Other barriers to care included how the treatment staff had performed their services. Focus group members said the staff often lacked empathy and treated patients poorly. M. Reed discussed the issues that parents in the focus groups felt were important. Some of these concerns included safety of their children, resources for emotional support, and trust in the staff.

E. Kelly said they used information from the Substance Abuse and Mental Health Services Administration (SAMHSA) website to find 1649 provider sites. After removing all sites that were not found in Philadelphia, they were left with 545 sites. They then removed all duplicate providers and lowered the number of providers they found to 330. After reconsideration, they decided to re-add providers who were inpatient treatment centers. The final number of providers on their GIS map was 367. A major issue they found was that some of the providers did not accept public insurance. The population of people they were interested in had mainly used public insurance. E. Kelly cited that 78-85% of those admitted to the emergency department for opioid poisoning were publicly insured. They went back to their list of providers and found 96 sites that did accept public insurance (26% of sites SAMHSA listed). E. Kelly said the sites they had looked at did not include places that were not primarily focused on substance use such as a church.

E. Kelly showed a map depicting inpatient sites and their proximity to NH Black and White populations. She noted that the inpatient sites were located within Black communities while inpatient sites were on the edge of NH White communities. She said this was a reflection of NH White populations' negative perception about having inpatient sites nearby. For Asian communities, inpatient sites were reasonably available in center city but more difficult to find in Northeast Philadelphia. E. Kelly said Hispanic communities had inpatient sites on the outskirts of their communities.

The next slide contained information about transportation and how it affected access. She said Philadelphia was one of the lowest cities in terms of car ownership and that many people used public transportation to access services. She noted that if a person could only walk to their service provider, they would not have many options for services. She concluded that many services could be challenging to reach depending on where the person lived in the city.

After concluding their project, E. Kelly and Reed shared the observed takeaways and recommendations. First, the project illustrated the treatment centers which allowed them to graphically see gaps in coverage. For example, the nearest OUD treatment center may not be the right level of care for an individual's needs. Another takeaway was that poor access to OUD treatment could be limited by where the person lived. E. Kelly said that creating a list of treatment centers was difficult and would be difficult for a person who was looking for treatment.

E. Kelly then talked about the survey they had sent to 10 program directors of methadone sites. The survey was completed by 9 program directors. The survey asked questions about subjects such as the impact of COVID-19, factors to prevent premature treatment termination, factors leading to administrative termination, patient supports and descriptive statistics.

E. Kelly then discussed the demographic information they had obtained from their survey. 93% of participants in the programs had public insurance. 57% identified as male, 42% of participants identified as female and 0.3% identified as transgender. 58% of participants were white and 27% of participants were Black.

The survey found that most sites did not have to change their hours during COVID-19. Only 2 sites said they had to close early or reduce hours due to staffing shortages. Most sites were not at full capacity in terms of staffing. On a systems level, the survey found that most sites voiced that their greatest difficulty during COVID-19 was staffing due to resignation and turnovers. On a patient-level, the greatest difficulty during the pandemic was the decrease of patient demand. E. Kelly then went over a list of ideas that the sites recommend to improve patient support such as housing, transportation, and a sense of community within the treatment program.

There were 4 main takeaways from the methadone survey. The first was that methadone programs were not at full capacity. The second was that lack of staffing was a major barrier for providing methadone services. Patients may also be shifting in their preferences for Methadone Opioid Use Disorder (MOUD) programs. The last takeaway was that methadone program directors did not see hours of operations and housing as a major barrier while those in patient focus groups did.

Based on the list of takeaways and the data, E. Kelly and M. Reed created a list of policy recommendations to improve access and retention in services. First, they suggested more user friendly, public-facing websites that identify locations and types of services available. Another suggestion was to improve service planning and evaluation through a comprehensive survey to assess the scale of OUD within Philadelphia. Regarding the assessment process, they suggested decreasing the wait time, paperwork burden, and improving withdrawal management. E. Kelly and M. Reed had suggestions regarding workforce development. They suggested expanding and supporting OUD service workforce with staff members that reflect the demographics and language preferences of those participating in services. They specifically suggested having more workers who spoke Spanish or other languages.

M. Reed reviewed the policy recommendation they had made. The first recommendation was the increase of financial, housing, and transportation resources to support people when initiating treatment. The second recommendation was to increase housing for all stages of recovery during transitions between levels of care. M. Reed suggested that they explore alternative treatment locations and expand efforts to provide expanded hours, mobile, wound, and outreach services. She said they recommend enhancing harm reduction services. They also encouraged less punitive approaches to address ongoing substance use during treatment through restricting or denying access to medication. She said they had also suggested improving linkage to treatment for incarcerated people upon release.

M. Reed reviewed the policy recommendations they made for inpatient services. One was to address the withdrawal from drugs such as xylazine and opioids. The second recommendation was to increase the number of treatment programs and continue efforts to create more inpatient beds for those who have complex comorbid conditions. They also recommended support for longer inpatient stays and initiate extensions earlier during stays.

E. Kelly and M. Reed concluded their presentation. They thanked the committee for the invitation and announced a new initiative at Jefferson Health called Jefferson Addiction Multispecialty Services (JAMS). E. Kelly said this was a dedicated team that would provide a comprehensive ecosystem of care for people who use drugs. E. Kelly then spoke about the Stephen and Sandra Sheller Bridge and Consult program. This program provided services such as post-acute care coordination, MOUD, full spectrum primary care, HIV/HCV/STI screening/ prevention/treatment, and recovery support with a certified recovery specialist. E. Kelly then spoke about Jefferson's Hospital to HOME Program Model. This program provided housing for patients who needed non-medical respite housing after leaving the hospital.

G. Grannan asked if they had tracked participants after they had left the treatment programs. M. Reed replied that they did not have the resources to track the participants long term, but they knew some participants had passed away from overdoses since the project had ended. K. Carter asked how many people in the focus groups were diagnosed with HIV. M. Reed replied that they did not know and it was an oversight in their project. They believed only one person had HIV in the survey. K. Carter asked the presenter to provide more details on the American Society of Addiction Medicine levels given to the inpatient centers. E. Kelly briefly gave an overview of the topic, noting that levels indicated how intensive the care was. For example, level 1 was walk-in care where the patient went in to pick up their medication. Level 3.5 was more intensive care and was the most common within the confines of Philadelphia. She said about a third of inpatient beds were not directly within the city limits and could present transportation issues.

Any Other Business:
None.

Announcements:
J. Ealy said they were having difficulty securing condoms for his organization. He said his organization was considering writing a grant to obtain condoms but wanted to avoid it. C. Steib said he remembered sending J. Ealy the contact of a person who could help but the contact that was sent forward was the same person J. Ealy was trying to reach. G. Grannan said he and his organization were having difficulty as well. B. Pearson suggested calling the DHH main phone number. J. Ealy said they had tried calling and were only getting voicemails. He then said they would try contacting Health Center 1.

Adjournment:
C. Steib called for a motion to adjourn. **Motion:** K. Carter motioned, G. Grannan seconded to adjourn the April Prevention Committee meeting. **Motion passed:** Meeting adjourned at 3:47 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- April 2024 Prevention Committee Meeting Agenda
- March 2024 Prevention Committee Meeting Minutes