Meeting Agenda

VIRTUAL:

Wednesday, November 21st, 2024

2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes CPC (October 17th)
- Approval of Minutes Prevention Committee (October 23)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - EHE Community Plan
- Other Business
- Announcements
- Adjournment

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

The next Prevention Committee meeting is
January 22, 2025 from 2:30-4:30
Comprehensive Planning meeting is
December 19th, 2024 2:00 - 4:00

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Comprehensive Planning Committee/Prevention Committee

Comprehensive Planning Committee
Meeting Minutes of
Thursday, October 17th, 2024
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Debra D'Alessandro (Co-Chair), Gus Grannan (Co-Chair), Nafisah Houston, Pamela Gorman, Gerry Keys, Lupe Diaz

Guest: Carolyn Ream, Jessica Browne (DHH), Laura Silverman (DHH), Blake Rowley (DHH)

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

Call to Order: D. D'Alessandro called the meeting to order at 2:06 p.m.

Introductions: D. D'Alessandro asked everyone to introduce themselves.

Approval of Agenda:
D. D'Alessandro referred to the October 2024 Comprehensive Planning Committee agenda and asked for a motion to approve. S. Moletteri said the agenda should be amended to replace Modalities of Prevention & Care with the CPC Recruitment Presentation. The presenter had a scheduling conflict and would be unable to attend. **Motion:** L. Diaz motioned; D. D'Alessandro seconded to approve the amended October 2024 Comprehensive Planning Committee agenda via Zoom. **Motion passed:** 4 in favor, 1 abstained. The amended October 2024 Comprehensive Planning Committee agenda was approved.

Approval of Minutes (*September 19th, 2024*):
D. D'Alessandro referred to the September 2024 Comprehensive Planning Committee minutes. **Motion:** G. Grannan motioned; D. D'Alessandro seconded to approve the September 2024 CPC meeting minutes via Zoom. **Motion passed:** 3 in favor; 3 abstained. The September 2024 CPC minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
S. Moletteri reported that the second presenter would not be able to attend the meeting. The committee would instead be working on the CPC Recruitment Presentation. Many members would be reaching their term limit and were required to step away from the HIV Integrated Planning Council (HIPC) for a year. The presentation was to help recruit HIPC members to sit on and chair the CPC in the future. G. Grannan, a co-chair of the CPC, would be reaching his term limit soon.

T. Dominique welcomed M. Ross-Russell back after she was absent due to illness.
S. Moletteri announced OHP would be tabling at the Stimulant Symposium at the DoubleTree Hotel and at the AIDS Walk event by the Philadelphia Museum of Art.

Presentation:
-CAREWare-
J. Browne introduced herself as the Manager of Information Services at the Division of HIV Health. She informed the committee that all the data they would see would be exclusively from fake test clients. She began her presentation with an overview of the Ryan White Services Report (RSR). This data report was submitted by subrecipients to HRSA every February. The report contained data elements that were defined by HRSA and were different for each service category. The goal was to have no more than 10% missing data by the time of submission.

J. Browne described CAREWare (CW) as a free HRSA-supported software for managing and monitoring HIV care. CW was programmed and maintained by a company called jProg. All funded Ryan White providers were required to use CW. J. Browne said CW was not centralized and that each service provider had their own version. She listed CW's main functions as follows: managing client records, running custom reports, tracking performance measures, improving quality, and maintaining RSR data.

After explaining what CW was and its purpose, J. Browne previewed what CW had looked like and explained how to use it. CW recorded clients' information such as name, gender, sex at birth, date of birth, zip code, race/ethnicity, HIV risk factors, vital status, enrollment status, Ryan White eligibility, and HIV Status. J. Browne explained that these fields were required because the information contributed to the RSR or performance measures. One of the most frequently asked questions was about the gender options in CW. CW allowed a provider to input Male, Female, Transgender, Female to Male Transgender, Male to Female Transgender, other, and Unknown. The options were defined by HRSA and could not be changed or edited by an individual user. As asked in previous HIPC meetings, J. Browne mentioned the concern that CW was unable to track history of incarceration. This meant that a CW user could be logged as incarcerated in the client's enrollment status, but once the client was no longer incarcerated, their new enrollment status would overwrite their incarcerated status. CW was unable to track a client's previous incarceration history. Next, J. Browne explained how HRSA guidance directed providers to enter their own service location as the zip code if the client was without housing or unstably housed.

T. Dominique asked if it was possible for two providers to enter different information on a client. For example, a provider may enter into CW that a client was incarcerated while another provider marked the client as not incarcerated. This discrepancy could potentially track incarceration history. J. Browne replied that since CW was not centralized it was possible. In order to track clients, DHH used an encrypted ID, so they would be able to see a client's history when initially viewing data. However, this would be corrected and any not-up-to-date data would essentially disappear.

J. Browne looked at the different options for enrollment status: active, inactive/case closed, incarcerated, referred or discharged, relocated, and removed. If a client was incarcerated, a provider would switch enrollment status to "incarcerated" since the client was no longer with their program. If a client returned to their program post-incarceration, they would change the enrollment status back to active. D. D'Alessandro assumed there was an exception for programs that provide case management and care to those who are actively incarcerated. J. Browne was not entirely sure but felt these programs selected "active" as the enrollment status and had other internal systems for tracking incarceration status.

J. Browne presented the committee with an example of what the services section in CW would look like. She stated that subrecipients were required to enter the date, contract name, service category, service name and number of units when they were recording data on services. Service units were defined differently for each service category. For example, some service units were measured in time while others were measured in number of client visits. Services were allowed to record whether a visit was a telehealth visit or an in-person visit. However, at that point, only O/AHS was required to track whether the visit was telehealth or not. Tracking these fields allowed DHH to gather data for their performance measures and reports to HIPC and other bodies.

In the annual review, providers were required to enter annual review data for one of the following in CW: housing, health insurance, poverty level, substance use, and mental health. The only category that providers were all required to enter data into was housing services. All core services had to enter data for health insurance. These fields were required for RSR reporting and Substance Use and Mental Health impact O/AHS performance measures. It was commonly asked if DHH knew of a client's substance use history or mental health diagnosis through the CW data. However, this was not how they knew. She said answering "yes" or "no" only referred to whether a client was screened for mental health/substances and not whether they had a history.

J. Browne described the fields that O/AHS were required to enter in their Lab and Screening Lab Data. They had to enter information for Viral Load, CD4, Hepatitis C, Gonorrhea, Chlamydia, Syphilis, Hepatitis B, and TB. They were also required to enter the following screenings in CW: Pap Smear, Colposcopy, Hysterectomy, Point-of-care and iART follow up. Medical Case Managers were required to enter information for screenings such as MCM Tier (comprehensive or standard) and the Service Care Plan Creation/Update.

In addition to everything J. Browne had previously mentioned, MCM providers were required to enter case notes (DAP notes) and data on medications into CW. O/AHS providers were also required to enter data on immunizations (HEP A/B) and medications (ART and PCP Prophylaxis). S. Moletteri asked if DHH ever used case notes in their data analysis. J. Browne replied that they did not use the case notes for data analysis. The only time they reviewed case notes was when the Program Services Unit conducted provider site visits.

J. Browne reminded the committee that CAREWare was not centralized. Providers using CW do not see any changes other providers make. DHH did not have direct access to subrecipients' CW

data. When DHH requested information from a provider, they must run a report on CW and submit the information to DHH through a secure channel on a secure File Transfer Protocol (FTP) site.

J. Browne described the different types of data reports they collected. The Finance Report represented the number of clients and units. This was collected quarterly. The Performance Measure Report collected data on O/AHS and MCM. DHH created a provider-level feedback report which showed subrecipients how their performance compared to their previous year. DHH also sent out a bimonthly aggregate report which showed the outcomes for each service across all the providers. The Provider Data Export was the export of all the CW data. DHH combined this data into one database and collected it quarterly.

The Women, Infants, and Children (WIC) Report was a breakdown of cotracts by gender and age submitted to HRSA. The RSR Report collected the required data elements for RSR to assess if providers were making progress towards reducing their missing data. The report was created and submitted three times per year. If a provider was missing information from their data entry, they would be asked to resubmit their information with the corrections.

J. Browne explained that DHH was very conscious about collecting data and only collected data that they needed or had used for. Some of the uses of the data were quality assurance, outcome reporting, fulfilling data requests, and clinical quality improvement.

Discussion Item:
-Committee Presentation-
At the last HIPC meeting, the Nominations Committee suggested that each committee create a presentation to recruit members to the subcommittees from the full council. The subcommittees were to create a presentation stating their responsibilities and goals. At a future HIPC meeting, each subcommittee would be given approximately five minutes to recruit new and existing HIPC members.

The subcommittee looked at the draft slides that S. Moletteri pulled up. K. Carter suggested that they add the meeting time to the first slide. The committee agreed to add that they met on the third Thursday of every month. On the "Meet Your Committee Members" slide, S. Moletteri added the names of the co-chairs. K. Carter suggested inserting the staff member assigned to the committee on this slide. S. Moletteri asked if they had wanted more than one speaker for their presentation. G. Grannan replied that they did not want to have too many speakers. The committee decided that they would revisit this topic on a different date once they had more of a final draft of their presentation.

T. Dominique asked if the co-chairs and other committee members would consent to adding their picture or be listed in the presentation to make it more personable. She explained that if a person saw a particular HIPC member they knew in the subcommittee, they might be more interested in joining that subcommittee. G. Grannan's and D. D'Alessandro's names were added to the presentation as the co-chairs. K. Carter and P. Gorman volunteered to add their names and

pictures to the presentation. S. Moletteri said if there were any other members who were interested in adding their names to the presentation, they could reach out to them after the meeting.

For the goals and responsibilities section of their presentation, S. Moletteri read descriptions of the CPC from the OHP website and the HIPC ByLaws. They asked if and/or which parts of the language could be incorporated into the presentation. P. Gorman suggested condensing the description on the OHP website. She said their goals were to make recommendations relevant to the Integrated HIV Prevention and Care Plan, priority setting, and other activities assigned by HIPC. G. Grannan suggested they add that the CPC also reconciled the long-term goals of the RW Plan and data from epidemiological reports and research. K. Carter said they had also assessed documented need for priority setting and ensured HIPC was well informed for allocations.

The committee would list the activities and responsibilities they had done to achieve their goals. The committee listed their work related to the priority setting process, Integrated Plan, Consumer Survey, epidemiological infographics, End the Epidemic (EHE) process, service standards review, and fulfilling data requests.

The next portion of the presentation answered the question of why a person would join the CPC and the benefits it presented both individually and for the community as a whole. On a personal level, the committee listed the following: (1) gaining familiarity with plan & epidemiological data to see how they influence each other, (2) seeing how programs are implemented and measured through DHH's reporting, (3) understanding what is going on and the behind the scenes of HIPC meetings since many topics come through CPC first, and (4) more room to exercise and grow your personal expertise.

As for community benefits, the committee listed the following: (1) CPC provided diverse voices for community, (2) the committee ensures programs are responsive to the community as represented by CPC members, (3) the committee is more focused on accomplishing tasks instead of observing formalities and allowed more room for expressing concerns and ideas than the full council, and (4) it presented a good opportunity to expose individuals to how community planning works and involve them in that process, both city and federal.

T. Dominique suggested that the committee work on brainstorming unique benefits, since much of what they had come up with could be applied to the other subcommittees as well. The committee suggested the following benefits unique to CPC: (1) CPC often decides what the whole HIPC focuses on/their direction and vice versa – HIPC gives "hot topics" to CPC to delve into, (2) CPC work filters in to every other committee, (3) CPC offers a unique perspective through involvement with data to uncover community needs, and (4) the committee helps the full council assess gaps in care to reach those better health outcomes, which is the ultimate goal of council work.

S. Moletteri said they could add a slide in the future to describe how CPC's work had benefited HIPC as a whole.

K. Carter asked if they could add their resource page to the chat during the presentation. M. Ross-Russell said it would be helpful to have a list and links to all the work that the CPC had accomplished. S. Moletteri agreed that this would be useful, suggesting they add several links to the presentations so people could go forth and explore more on their own. They suggested combining the links together in one document for easier accessibility. S. Moletteri said they would email the document after the meeting after they gathered the links.

The last slide had K. Trinh's email address listed as the staff member to contact if a member was interested in joining the CPC. S. Moletteri said they would be creating a survey to send HIPC members at the end of each presentation to gauge interest in the committee.

Other Business:
None.

Announcements:
None.

Adjournment:
G. Grannan called for a motion to adjourn. **Motion:** L. Diaz motioned, K. Carter seconded to adjourn the October 2024 Comprehensive Planning Committee meeting. **Motion passed:** Meeting adjourned at 3:50 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2024 CPC Meeting Agenda
- September 2024 CPC Committee Meeting Minutes

Prevention Committee
Meeting Minutes of
Wednesday, October 23rd, 2024
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Veronica Brisco, Lorett Matus, Clint Steib (Co-Chair), Desiree Surplus (Co-Chair), Mystkue Woods

Guest: Sigfried Aragona (DHH), Harlan Shaw (DHH), Jackson Suplita (DHH), Maggie Webb (Philadelphia FIGHT), Javontae Williams (DHH)

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 October 2024 Prevention Committee agenda and asked for a motion to approve. **Motion:** L. Matus motioned; V. Brisco seconded to approve the October 2024 Prevention Committee agenda via Zoom poll. **Motion passed:** 4 in favor, 2 abstained. The October 2024 agenda was approved.

Approval of Minutes (*September 25th, 2024*):
C. Steib referred to the September 2024 Prevention Committee Meeting minutes. **Motion:** L. Matus motioned; M. Woods seconded to approve the September 2024 Prevention Committee meeting minutes via a Zoom poll. **Motion passed:** 5 in favor; 2 abstained. The September 2024 minutes were approved.

Report of Co-chairs
C. Steib announced the November meeting would be a combined meeting between the Prevention Committee and the Comprehensive Planning Committee (CPC). He reminded the committee that his term would be ending next year and he was still looking for someone to take his seat. He asked those interested to contact S. Moletteri, T. Dominique, or himself.

Report of Staff:
T. Dominique reported that she, S. Moletteri, and K. Trinh had tabled at the Stimulant Conference and the AIDS Walk to offer resources and recruit new members to HIPC.

J. Williams took some time to welcome J. Suplita to his team. J. Suplita had been working at the Philadelphia Health Department for a year and was recently transferred to J. Williams's team.

Presentation:

-PrEP Week Synopsis/Recap-

M. Webb was introduced as the Pre-exposure prophylaxis (PrEP) Program and Outreach Manager at Philadelphia FIGHT. She had joined Philadelphia FIGHT in April and was invited to the Prevention Committee to recap PrEP week.

For those unfamiliar, M. Webb explained that PrEP week was a week of free community events to promote PrEP and HIV prevention. The event had started in 2019 and had the goal of raising awareness, increasing uptake of PrEP, and encouraging communication with providers and health professionals. After reflection on the 2024 PrEP Week, Philadelphia FIGHT aimed to add additional goals for outreach in 2025. The organization sought to re-establish themselves after the pandemic and boost community partnerships. With the limitations on harm reduction resources in the city, they also wanted to focus on PrEP in people who inject drugs (PWID).

FIGHT had an event on each workday. On Monday, FIGHT held information sessions and a town hall. The next event on Tuesday was the Teen Creative Drop-In Space. She said the Incentivized Testing with Harm Reduction Partners events on Wednesday was canceled. On Thursday, FIGHT held their Pleasure and Protection Bingo-Quizzo. This was their most popular event. On Friday, they held their PrEP Week Symposium.

M. Webb briefly went over each event while highlighting the successes they had found and the lessons learned from hosting the events. She started with an overview of the Monday Community Information Sessions and Town Hall. The Town Hall was an informal question and answer session with 25 attendees with no more than 10 community members. She was pleased that there was great engagement with the audience who learned much about preventative medicine and how the medicine may interact with other medications they were taking. Clinical staff members were appreciative that they were able to meet the community members and listen to a presentation by a non-clinician on PrEP. They found that it helped them find more ways to communicate with community members about the importance of preventative medicine. From this event, they had learned that the event location was important and that future events should be at places community members frequented. As a point of improvement for the future, they were considering more thoughtful advertising that recognized what might incentivize people to attend events. This included understanding community member priorities. For example, a community member would not likely attend an event on the same day as a sports event.

Their second event was their Teen Creative Drop-in Space. The event had art supplies, games, and dinner. The event only had one attendee. Because of low attendance, M. Webb said they had many lessons to learn from this event. The first was that the focus of the event needed to be clear to community members. The event was intended to have a variety of activities and needed to advertise in a way that better incentivized teenagers to their event. The second lesson they had learned was that they needed people who represented the participants they were trying to reach. Like the last event, the importance of the event location was something they had to learn from. C. Steib suggested that they host an event at the Attic Youth Center. M. Webb said they had tried to contact the youth center for this event but the plans to host an event there had fallen through.

M. Webb provided more detail on the event that was supposed to be held on Wednesday and why it was canceled. She explained the plan to offer incentivized testing with The Everywhere Project, a grassroots harm reduction organization. Their plan was to rent out a van and meet up with The Everywhere Project at Love Park. Unfortunately, they were unable to assemble necessary staff and providers in time to have the event. M. Webb was disappointed because this event was the only one aimed at increasing PrEP coverage during the week. They were hoping to host the event in February 2025, but realistically felt it would actually take place in the spring.

The Pleasure and Protection Bingo-Quizzo was their most popular event. It was hosted at 13th & Locust. The event consisted of a bingo game with sexual health trivia, open bar, free food, and sex toy prizes. About 60 people attended the event. They learned that they preferred events where they hosted nightlife events instead of traveling to a place with nightlife. They found that hosting the nightlife event yielded a different type of audience that was more open to making connections and engaging with the material. However, this also meant that many of the attendees were already aware of PrEP.

Philadelphia FIGHT finished PrEP week with the PrEP Week Symposium. The event was held at the Science History Institute on 3rd & Chestnut and had 45 attendees. It was a half-day conference with 2 didactics, 1 panel and reception. She said the symposium content was great and praised the Science History Institute as a great location for events. From the event, they had learned that they needed to hold events on days that their audience could attend. Although the conference was a half-day conference, many potential participants said they could not attend due to work. The conference offered Continuing Medical Education credits, but they found it was not enough of an incentive to drive people to the event. She said they were very conscious of the idea that they may not be reaching out to community members as much as they needed to.

Dr. Wei-Teng Yang, the head of Infectious Disease and Addiction Medicine Integration at Penn Medicine, had presented at the symposium. M. Webb said their presentation was one of the highlights of the symposium. They presented on PrEP and PWID in Philadelphia, Methadone as PrEP, street medicine sustainability, and long acting injectables. Another person who had presented was J. Tanguay who was a program lead at Whitman-Walker Health. Their presentation was on the Care Home Model, navigation of political resistance against harm reduction strategies, and chemsex.

Looking forward to 2025, M. Webb said they were excited to have incentivized testing with the Everywhere Project and their youth events. She said they would be applying what they had learned from PrEP Week in future events. In addition, they were exploring other opportunities to collaborate with grassroots organizations focusing on topics outside of their clinical space such as trans safety, gun violence, and abortion.

Discussion Item:

-Prevention Committee Recruitment Presentation Review-

As mentioned in the previous HIV Integrated Planning Council (HIPC) meeting, each subcommittee was to create a 5 minute presentation to recruit new members. L. Matus asked about the difference between the “Who We Are” and the “About the Committee” bullet points on the agenda slide. T. Dominique felt that “About the Committee” described the subcommittee's

primary goal. On the "goal" slide, T. Dominique had placed the descriptions from the Office of HIV Planning website and the HIPC ByLaws. C. Steib and L. Matus felt that the language used was too formal. The committee wanted to describe themselves as the committee that represented the community because they brought the community feedback to DHH and the other committees.

The committee reviewed the "Meet Your Committee Members" slide. She asked the members if they had wanted their names and photos added to the presentation. C. Steib, D. Surplus, V. Brisco, and L. Matus volunteered to have names and pictures added to the presentation.

On the "Roles and Responsibilities" slide, the committee members would list what they did as a committee. The committee decided that they provided prevention-related recommendations to HIPC, forwarded feedback from the community to DHH, worked closely with the CPC, covered relatable topics in real time, helped established the city PrEP program, invited speakers to inform about the prevention process, helped to inform about the pillars of the End the Epidemic (EHE), planned and used data to help inform decisions during the allocations process.

The next slide addressed why a person should join the Prevention Committee. The members listed the personal and community benefits of being a Prevention Committee member. After much discussion, the committee decided that the community benefited from the Prevention Committee because it created an informed community and allowed members to be a representative for those who did not have a voice in the decision making process. On a personal level, joining the Prevention Committee helped members gain more professional development and become more familiar with the multiple processes.

T. Dominique added the day and time on which the Prevention Committee had often met. L. Matus suggested that they add links to the previous meeting minutes in the presentation. C. Steib requested the presentation slides so he could have more time to look at the presentation more closely. T. Dominique said they would not have a meeting on the presentation until January since they had their combined meeting with the CPC in November and would not meet in December due to the holidays. The committee decided that they would continue their discussion on the presentation through email.

Any Other Business:
None.

Announcements:
None.

Adjournment:
C. Steib called for a motion to adjourn. **Motion:** L. Matus motioned, V. Brisco seconded to adjourn the October Prevention Committee meeting. **Motion passed:** Meeting adjourned at 3:55 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2024 Prevention Committee Meeting Agenda
- September 2024 Prevention Committee Meeting Minutes