Meeting Agenda

VIRTUAL:
Thursday, October 13, 2022
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(September 8, 2022)*
- Report of Co-Chairs
- Report of Staff
- Discussion Item:
  - MPV Discussion *with Dr. Cheryl Bettigole*
- Action Item:
  - HIPC Co-Chair Election
- Presentation:
  - Integrated Plan Goals & Objectives
- Committee Reports:
  - Executive Committee
  - Finance Committee – *Alan Edelstein & David Gana*
  - Nominations Committee – *Michael Cappuccilli & Juan Baez*
  - Positive Committee – *Keith Carter*
  - Comprehensive Planning Committee – *Gus Grannan*
  - Prevention Committee – *Lorett Matus & Clint Steib*
- Any Other Business
- Announcements
- Adjournment

HIV Integrated Planning Council

Please contact the office at least 5 days in advance if you require special assistance.
The next HIPC meeting is
VIRTUAL: November 10, 2022 from 2:00 – 4:30 p.m.

VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, September 8, 2022
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Mike Cappuccilli, Keith Carter, Debra D'Alessandro, Alan Edelstein, Gus Grannan, Julie Hazzard, Sterling Johnson, Gerry Keys, Greg Langan, Dr. Marilyn Martinez, Lorett Matus, Hemi Park, Sam Romero, Evan Thornburg (Co-Chair), Adam Williams

Guests: Evelyn Torres (AACO), Ameenah McCann-Woods (AACO), Mike Valentine (AACO), Ahmea Branch (AACO)

Excused: Sharee Heaven (Co-Chair), Lupe Diaz (Co-Chair), Jose DeMarco

Staff: Mari Ross-Russell, Sofia Moletteri, Debbie Law, Beth Celeste

Call to Order: K. Carter and M. Cappuccilli volunteered to chair the meeting since the co-chairs were not able to attend. K. Carter called the meeting to order at 2:07 PM. He asked everyone to introduce themselves in the chat.

Approval of Agenda:
K. Carter presented the September 2022 Planning Council agenda for approval. **Motion:** Julie made a motion to approve the September 2022 agenda, G. Keys seconded to approve the amended agenda. **Motion passed:** 11 in favor, 2 abstaining.

Approval of Minutes (*August 11, 2022*)
K. Carter presented the August 2022 meeting minutes for approval. Sam must be excused. **Motion:** L. Matus motioned and G. Keys seconded to approve the August 2022 meeting minutes. **Motion passed:** 8 in favor, 5 abstaining.

Report of Co-Chairs:
No report. E. Thornburg said she would have to leave the meeting early.

Report of Staff:
M. Ross-Russell reported that they were still short-staffed. As they went through the process, S. Moletteri was both overseeing Zoom and taking minutes. The position for the Community Planning Support Coordinator and Health Planner Website Coordinator had been posted. They appeared in three different locations—LinkedIn, Indeed, and PHMC's website.

M. Ross-Russell reported that as of Wednesday afternoon, they had entered about half. They were looking at about 220 because some of the surveys were incomplete. She had forwarded some of the information to AACO to look at, but they would have to do a full analysis on SPSS.

M. Ross-Russell said they were still looking at receiving the HIPC reapplicants and waiting for people to send that in. D. Law said that the people who still needed to reapply were not currently in the meeting.

A. Williams asked why the job posting did not appear in the OHP website. M. Ross-Russell said that they would do that.

S. Moletteri reported that they were still entering the surveys and were a little over halfway through. There were some surveys from people who were not living with HIV, but they were still entering them. She added that there were many from incarcerated individuals who were not living with HIV, so it was good to get this representation regardless.

Presentations:

—Integrated HIV Prevention and Care Plan—

K. Carter introduced E. Torres to present on the 2022-2026 Integrated Plan. Please refer to the presentation titled "August AACO Presentation to HIPC Integrated Plan" for details.

She explained that she was the Program Implementation Administrator at AACO. She would present with M. Ross-Russell to present on progress for the Integrated Plan. They would have time for a discussion at the end.

Today, she would discuss the background for the plan—what was to be included in the plan and HIPC's participation. They would follow the guidance document and submit it by the end of the year. On the last slide, there was a link for those who wanted to look at the federal guidance.

As for background, this was a document that set out recommendations for all HIV care and prevention, including but not limited to the RWHAP and CDC prevention funding. The plan was issued by the CDC and HRSA in 2015 and 2021. On the third slide titled *Background*, E. Torres read what the plan was intended to do.

She read the next slide titled *Federal Expectations.* She added that this was important since Philadelphia was a Phase 1 Ending the Epidemic (EHE) jurisdiction due to the infection rates. Therefore, they crafted an EHE plan and got concurrence from the HIPC. EHE would inform the Integrated Plan. In turn, the Integrated Plan would assist with updating the EHE plan. These two plans would be in coordination to further the NHAS goals. At AACO, they had been working to ensure that all three plans were consistent with each other. NHAS was released in August 2022. The EHE plan was Philadelphia-specific, but the Integrated Plan would be EMA-wide.

She next read the *Sections to Be Completed* slide. She explained that SCSN stood for Statewide Coordinated Statement of Need. This was a responsibility of the states. Since the plan addressed the EMA, they would work closely with the PA and NJ Departments of Health.

E. Torres next looked at the description the first section under the slide *Section I: Executive Summary.*

Next was a description of the second section under the slide *Section II: Community Engagement and Planning Process.* She explained that for community engagement, they had an 18-month process for the EHE plan. They had many virtual town halls (due to COVID-19) for funded providers and communities most affected by HIV. They also worked with the HIPC to gather information. They also used data like NHBS (National HIV Behavioral Surveillance) which focused on interviewing three priority populations. These were done in annual cycles. There was also the DExIS project which was funded by the CDC and recently ended. These interviews gathered people's experiences with HIV testing and prevention. Another project was the MMP (Medical Monitoring Project) which gathered information through interviews on behaviors, clinical outcomes, and barriers to care and suppression for PLWH.

She next read the slide titled *Section III: Contributing Data Sets and Assessments.* Essentially, this plan was supposed to be data-driven. This would provide the basis for the goals and objectives. They worked closely with the PA and NJ counties for their surveillance data and also used their own, Philadelphia data. Additionally, throughout the Integrated Plan, they were required to follow requirements for RWHAP as well.

She next read the slide titled *Section IV: Situational Analysis.* They had the EHE Situational Analysis and could also look to the states.

She next read the slide titled *Section V: 2022-2026 Goals and Objectives.* She noted that all the prior slides/sections would inform the goals and objectives. Additionally, Diagnose, Treat, Prevent, and Respond were also pillars of the EHE plan. E. Torres added that E. Thornburg was leading the efforts for the equity activities within the plan. HIV disproportionately affected certain populations, so this was a key part to ending the HIV epidemic.

She next looked at the *EXAMPLE GOAL STRUCTURE Diagnose XX% of people with HIV* slide, explaining that this was an example structure.

Next was the slide titled *Section VI: Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up.* The goals would have clear measurables and data indicators that they could look to when monitoring and reporting.

M. Ross-Russell next looked at the slide titled *Section VVII: Letter of Concurrence.* This letter was the process of HIPC reviewing and concurring, concurring with reservations, or not concurring with the plan. The HIPC assesses the plan to see if it fulfilled the requirements put forth by the CDC and HRSA. Once the plan was relatively complete, HIPC would be involved and receive additional presentations. There were plans to present in both October and November. This section would be the last piece of the plan.

E. Torres read the schedule on the *HIPC Participation* slide. The next meeting, they would review the goals and objectives. In the November meeting, they would focus on the letter of concurrence.

M. Cappuccilli asked for more information on the EHE, NHAS, and SCSN and how they would inform the Integrated Plan. E. Torres noted that the EHE plan was Philadelphia-specific. The Integrated Plan was EMA-wide and would require working with the states. NHAS, she said, was a national document released in August. It put forth goals and strategies from a national lens. M. Ross-Russell explained that the SCSN was essentially the states' individual Integrated Plans.

M. Cappuccilli asked the deadline for the plan. E. Torres responded December 9th, but they were hoping to submit the plan by November 30th.

K. Carter asked if the goals and objectives could be sent out to the HIPC before the October 13th meeting. E. Torres said she would send what they had completed.

—Year End Spending Report—

A. McCann-Woods explained that the reconciliation of total invoices forwarded to AACO for processing through August 31, 2022 indicated five percent (5% or $1,200,053) underspending of the total overall award (including MAI funds).

In Philadelphia there was underspending in EFA-Pharma ($63,880) due to decreased utilization, EFA-Housing ($434,605) due to decreased utilization, and Substance Abuse ($96,490) due to vacancies. She noted that in Housing, this did not necessarily mean a decreased need. There were many other funding streams and COVID dollars which led to a decrease in utilization, not need.

As for overspending in Philadelphia, Housing assistance was overspent by $60,666 and EFA was overspent $54,585. Both were due to overutilization.

In PA Counties, there was underspending in EFA-Pharma ($120,758) due to decreased utilization, and Housing Assistance ($719) due to decreased utilization.

As for overspending in PA Counties, EFA was overspent by $9,326 and Mental Health was overspent $23,158. Both were due to overutilization.

In NJ Counties, there was underspending in Medical Case Management ($87,510) and EFA-Housing ($106,394). Once again, due to availability of COVID-19 funds, RWHAP funds went underutilized. She noted that this did not dimmish need in this area of the jurisdiction.

As for overspending in NJ Counties, Medical Transportation Services were overspent by $30,069 due to higher utilization.

Regarding Systemwide Allocations, I&R (recipient) was underspent by $132,114, QM Activities (recipient) by $119,358, Capacity Building (recipient) by $91,213, and Grantee Administration (recipient) by $171,633. All were due to vacancies, and any identified underspending had been reallocated to direct service categories.

As for MAI Systemwide Allocations underspending, QM Activities was underspent by $12,863 due to vacancies. As usual, any identified underspending had been reallocated to direct service categories.

S. Johnson felt there was not a decreased use of housing. A. McCann-Woods agreed, but as far as RWHAP Part A dollars, it was. S. Johnson said people without housing was a huge issue. He suggested that the money needed to be spent in a different way or method. Or, they needed to ensure that individuals were aware of available housing funds. A. McCann-Woods said the dollars were not usually underspent, and this was more about other resources being utilized before RW Part A. S. Johnson said he was talking specifically about PLWH in Philadelphia. E. Torres said that in Philadelphia, people wanted ongoing subsidized housing and RWHAP could not support this legislatively. Additionally, the EMA received COVID dollars from Part A, the state, and the City of Philadelphia. These dollars had to be used first. S. Johnson said housing needed to be pushed, not in just this space, but all spaces. He said spending was not reaching enough or the right people. A. McCann-Woods and E. Torres agreed. A. McCann-Woods said that even if all the money was spent out, it would not eradicate the issue. It was a huge problem in Philadelphia and elsewhere, so she agreed with S. Johnson on the gravity of the issue.

—1Q Spending Report—

A. McCann-Woods reported that this was spending through May 31st. She asked everyone to keep this in mind as they moved forward.

She explained that reconciliation of total invoices forwarded to AACO for processing through May 31, 2022, indicated twenty-three percent (23% or $1,339,930) underspending of the total overall award (including MAI funds). Expenditures through Q1 demonstrated increased underspending due to late conformance of contracts. Subsequent spending reports would demonstrate improved actual spending apart from hospitals and the two fiduciary entities (PHMC and UAC). Inherently have cumbersome fiscal processes which results in delays submitting invoices and budgets.

A. McCann-Woods mentioned that the slides included percentages alongside the dollar amount to represent the percentage of the balance of funds. This was previously requested by the HIPC to further understand the amount spent out as it compared to the award amount for each service category.

She first read the underspending for Philadelphia. Outpatient Ambulatory Care was underspent by 278,263 or 23% due to late invoicing, delayed spending on operating expenses, and leveraging other funding sources. Medical Case Management was underspent by $156,619 or 16% due to vacancies, late invoicing, and delayed spending on operating expenses. Drug Reimbursement was underspent by $57,090 or 47% due to late invoicing and delayed spending on operating expenses. Oral Health was underspent by $18,907 or 18% due to delayed spending on operating expenses and leveraging other funding. Substance Abuse Outpatient was underspent by $32,984 or 25% due to vacancies and delayed spending on operating expenses. EFA-Housing was underspent by $46,130 or 37% due to leveraging other funding from safety net programs. Lastly, Transportation was underspent by $2,376 or 79% due to leveraging other funding. There

was decreased utilization, but this trend continued to change because clients were engaging with more in-person services.

As for Philadelphia overspending, EFA-Pharma was overspent by $7,206 or 13%, EFA was overspent by $26,166 or 220%, and Food Bank was overspent by $35,685 or 70%. All were due to higher utilization.

A. McCann-Woods next read PA Counties underspending. Medical Case Management was underspent by $30,907 or 10% due to vacancies, late invoicing, and leveraging other funding. EFA-Pharma was underspent by $33,086 or 74% due to leveraging other funding (SPBP continued to be a great resource in getting clients to access medications quickly). Food Bank was underspent by $9,875 or 55% due to late invoicing, delayed spending on operating expenses, and leveraging other funding. Housing Assistance was underspent by $8,590 or 21% due to decreased utilization (COVID funds still played an integral part in getting individuals the assistance they needed).

As for PA Counties overspending, EFA was overspent by $4,256 or 72% due to higher utilization.

As for NJ Counties underspending, Outpatient Ambulatory Care was underspent by $36,115 or 13% due to late invoicing, delayed spending on operating expenses, and leveraging other funding. Medical Case Management was underspent by $46,197 or 43% due to vacancies and late invoicing. Mental Health was underspent by $10,221 or 24% due to vacancies and late invoicing. Oral Health was underspent by $49,403 or 100% due to late invoicing, delayed spending on operating expenses, and leveraging other funding. Food Bank was underspent by $13,718 or 100% due to late invoicing and leveraging other funding.

Regarding NJ Counties overspending, Transportation was overspent by $38,716 due to higher utilization.

Systemwide Allocations underspending are as follows: I&R (recipient) by $139,971 88%; QM (recipient) by $69,175 or 50%; Capacity Building (recipient) by $23,210 or 81%; PC Support (planning council) by 134,276 or 100% ; and Grantee Administration by $205, 570 or 65%. All of this was due to vacancies. Specifically with PC Support, basic overhead costs had gone down due to remote work. Spending would increase now that contracts had been conformed. She mentioned that due to cumbersome hiring practices and late contract conformance at the Recipient level, underspending was a result. Moreover, all underspending had been or would be reallocated to direct service categories.

A. McCann-Woods mentioned that last month, someone had a question about Home Health Care services. She said that as for RWHAP Home Health Care, it was for RW eligible individuals and to be administered by a licensed professional. Individuals using the service would receive therapeutics, preventative and specialty care, wound care, routine diagnostics, etc. She said the utilization for this service declined every year. At the end of FY2021, they had a total of 8 clients, and this fiscal year they had a total of 2 clients. As far as RWHAP clients, the amount of individuals using the service was low.

As for Home Health AIDS, they helped with personal care, dressing, bathing, etc. Medicare only paid for Home Health Personal Care AIDS when an individual received skilled nursing care or rehab services through Home Health Care. This was not a standalone service. Additionally, clients must be 65 years old or older to qualify and receive a professional level of care. They must be a permanent resident of their state as well. As for income limit, individuals must make $1,379/month or under and married couples must make $1,851/month for married couples.

Pennsylvania and New Jersey Medicaid program paid for a nursing home or home care if the individual had limited income and assets and the doctor certified that they needed the care.

A. McCann-Woods read some other considerations:

- Medicare Parts A and B cover eligible home health services
- Some of the services include: physical therapy, OT, speech therapy, medical social services, durable medical equipment, PT or intermittent home health care aide and more
- Medicare does not pay for: delivered meals, 24-hour day care at the home, home maker services, custodial or personal care.
- Your costs can be $0 for covered home health care services. If you meet Part B deductible, 20% of the Medicare-Approved amount for Medicare-covered equipment. Medicare will (or should) tell you how much you have to pay.
- Some RW beneficiaries would qualify for dual Medicare/ Medicaid where Medicaid would pay for the home health services.

A. McCann-Woods put 1-800-medicare was in the chat, since the situation differed from person-to-person.

K. Carter asked if she could summarize what she had stated for RWHAP clients. A. McCann-Woods said that RWHAP Home Health Care services were covered. In this jurisdiction, she explained, the service was not funded, but they supported the service through Philadelphia general funds since there were such few individuals who needed it. Custodial and personal care was covered through RW—it was slightly easier in terms for eligibility when compared to Medicare and Medicaid. She could provide the link and information to OHP staff to distribute.

K. Carter was surprised the service was underutilized since over 50% of PLWH in Philadelphia were 50+. A. McCann-Woods said this was not just about age, unfortunately, they needed to have documented need of medical assistance. E. Torres said they had seen decrease, because they have been able to clients funded through Medicaid. Under Medicaid, there were certain waivers that allowed people to receive more income and still be eligible for the service.

Action Item:

—MPV Letter from Poz Committee—

K. Carter said that the letter was for Dr. Brady in AACO about messaging around Monkeypox (MPV). S. Moletteri scrolled to the letter which was included in the meeting packet.

K. Carter said they had discussed the stigmatizing language which was reminiscent of stigmatizing language around HIV. They wanted to ensure they were cognizant of language distribution so certain populations were not targeted. The Positive Committee wrote this letter. S. Moletteri noted that the bottom signatures might change since Lupe was up for nomination. If the HIPC co-chair, and thus signature, changed, HIPC would need to approve the letter as a representation of their stance on MPV messaging. They would do this with the knowledge that the signature lines may change. For transparency purposes, K. Carter added that this letter was mostly written by J. DeMarco, himself, and S. Moletteri.

S. Moletteri read the letter to the group.

K. Carter opened up the floor for comments on the letter.

A. Edelstein though the letter was great. G. Grannan liked it but asked to emphasize stigmatization and how this had negative epidemiologic affects. This was a virus that did not only affect queer and MSM populations. Focusing on only one or two populations would prevent people from getting the care they needed.

J. Williams said that Dr. K. Brady was not part of the MPV team. AACO was asked to work the division who was leading the charge, but they were not leading the charge themselves. He felt they should write to Dr. C. Bettigole, the Health Commissioner, since she had the final say for MPV messaging. Additionally, he added that they were ensuring that all people had access to the vaccines. Only 25% of people vaccinated were black and brown men. There were clear disparities here and this may be due to location. He also suggested that they shorten the letter, state who they are, and state their demands. If there was further conversation to be had, then they could make room for this.

M. Ross-Russell said they had discussed who the letter should be addressed to internally. They suggested giving the letter to Dr. K. Brady so as to not overstep her and go immediately to the Health Commissioner. E. Torres said she ask Dr. K. Brady about preferred method for the letter. Potentially, they could send this directly to the Health Commissioner and CC Dr. K. Brady.

Dr. M. Martinez added that in Philadelphia, there were now more places that were getting ready to roll out the vaccine. The vaccine was now much more accessible so they were adding more places to administer the vaccine. G. Keys said Health Centers had been calling PLWH and PrEP patients to offer the MPV vaccines. Some agreed to receive the vaccine, but many more were declining the vaccine. Keith said that at first, people were receiving a full dose and now they were receiving smaller doses. He wanted to ensure that there was more clinical data to understand efficacy and gain trust. G. Keys said that some doctors had taken the vaccine, so there was trust on the clinical side. She understood how this may cause distrust, however.

M. Ross-Russell said the language would change to some degree (this included a potential change in who the letter was addressed to and who was signing it). She asked what they would want to do next. Keith said they could take note of the suggestions and make the changes. A. Edelstein said the letter was coming from the HIPC as a whole, so they would have to vote on this. He suggested they vote to approve charging a specific group with making the suggested

changes and then sending it out. M. Ross-Russell said the motion from the Positive Committee would need to be amended so that the Positive Committee could make the changes and distribute the letter.

E. Torres reported that Dr. K. Brady was comfortable with sending the letter directly to the Health Commissioner.

Motion: A. Edelstein motioned that the people who had been working on the MPV letter receive responsibility to complete and send out the letter based on HIPC's suggestions and discussion, M. Cappuccilli seconded.

G. Langan: in favor
M. Cappuccilli: in favor
G. Grannan: in favor
K. Carter: in favor
A. Edelstein: in favor
A. Williams: in favor
G. Keys: in favor
S. Romero: in favor
L. Matus: in favor
Dr. M. Martinez: in favor
D. D'Alessandro: in favor
S. Johnson: in favor

Motion approved: 12 in favor, 0 against, 0 abstaining.

—EPI PA Counties Letter from Finance Committee—

A. Edelstein said they had a discussion about this in the Finance Committee and he wrote it based on that.

A. Edelstein summarized the content of the letter. He explained that the data given for PLWH within the PA Counties was 4,761 in 2019 and 4,248 in 2020, a reduction of 10.78%. They had not received an explanation as to why there was a decrease of about 500 people. This letter requested an explanation for said reduction. Since the reduction affected funding, the committee decided they needed a sound explanation. At the bottom of the letter, A. Edelstein included room for members of the Finance Committee to sign.

Please refer to the letter for more information.

A. Edelstein asked if they would have to vote on the letter since it was just coming from the Finance Committee. M. Ross-Russell said the HIPC would still need to approve this since it still represented the HIPC in some way.

A. Edelstein opened the floor for comments, questions, and suggestions.

Motion: A. Edelstein motioned to approve the EPI PA Counties Letter from the Finance Committee to Dr. Obiri as recommended by the Finance Committee.

G. Langan: in favor
M. Cappuccilli: in favor
G. Grannan: in favor
K. Carter: in favor
A. Edelstein: in favor
A. Williams: in favor
G. Keys: in favor
S. Romero: in favor
L. Matus: in favor
Dr. M. Martinez: in favor
D. D'Alessandro: in favor
S. Johnson: in favor

Motion approved: 12 in favor, 0 against, 0 abstaining.

Discussion Item:

—HIPC Co-Chair Nominations—

M. Ross-Russell said that every year there was a process by which they take co-chair nominations for one of the two co-chair positions. They stagger the voting so each year they have one person carrying over for the two year term. This way there were no gaps in leadership. This particular time, the co-chair that was up was L. Diaz's chair.

They would open up the chair positions for nominations. Lupe has expressed her interest in continuing. They left the nomination open for 30 days so they would vote in October. The position was for members in good standing who had been a HIPC member for more than a year.

During these processes, she said, the HIPC co-chairs tend to abstain when voting. The reason is because the co-chairs facilitated the meeting and were therefore neutral parties in discussions. Therefore, for those who feel they want to keep expressing themselves fully and in an uninhibited manner, the position may feel limiting. M. Ross-Russell said they could nominate in the chat, over the mic, or even email her at mari@hivphilly.org within that 30-day window.

K. Carter nominated Lupe.

If new to the process, she asks that people give background on who they are to the HIPC.

Committee Reports:

—Executive Committee—

None.

—Finance Committee—
No further.

—Nominations Committee—
M. Cappuccilli reported that they met informally before this meeting to discuss membership. They had 41 members currently, and they would be below the minimum requirement of 35, so they discussed how they should operate going forward. They decided to reach out to organizations and see if anyone was interested. D. Law added that people should reach out internally to their organizations. K. Carter said the application was quick to complete.

—Positive Committee—
No report.

—Comprehensive Planning Committee—
G. Grannan reported that they finished with allocations, so they are looking into the EPI profile and the beginning of the next cycle. If anyone was interested in participating, get in touch with S. Moletteri.

—Prevention Committee—
L. Matus reported that they spent a lot of time reviewing the updated and bilingual portions of the PhillyKeepOnLoving website.

Other Business:

A. Williams said there was an important federal court decision in Texas that addressed PrEP coverage under ACA. They found that defendants had not shown that PrEP mandate furthered a compelling interest for the government. Overall, they found the mandate to infringe upon religious beliefs of insurance agencies. This had substantial impacts for the EHE and coverage. They were unsure it would be turned over but they had to take it seriously. He suggested HIPC and Prevention Committee look into it. K. Carter asked if this was federal or state. A. Williams said the case came out of Texas, but the ruling applied to the whole country. M. Ross-Russell said there was a lot of pushback on this ruling and it would likely be appealed.

A. Williams said he spoke with J. Williams and AACO was working to draft a statement. They should pay close attention and respond if needed.

Announcements:

None.

Adjournment:
K. Carter called for a motion to adjourn. **Motion:** L. Matus motioned, A. Edelstein seconded. Meeting adjourned 4:10 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- September 2022 HIPC Agenda
- August 2022 HIPC Meeting Minutes
- MPV Letter from Positive Committee
- PA Counties EPI Letter to Dr. Obiri

Department of Public Health
CITY OF PHILADELPHIA

AIDS Activities Coordinating Office

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Diagnose

Goal 1: To diagnose 95% of Persons Living with HIV (PLWH) by 2026

Objective 1: Promote routine opt-out HIV screenings and diagnostic testing in 50 healthcare and other institutional settings by 2026.

Objective 2: Maintain HIV testing services in priority non-clinical settings cited in the activities.

Objective 3: Implement novel HIV testing initiatives.

Goal 2: Eliminate Disparities in non-clinical HIV Testing

Objective 1: Increase the number of partners to address syndemics to reduce new HIV diagnoses.

Objective 2: Increase HIV testing among priority populations by 20%.

Objective 3: Enhance health equity efforts through policy and process improvements annually.

Objective 4: Evaluate HIV testing programs to address disparities in priority populations annually.

Goal 3: Strengthen the HIV workforce including collaboration with NJ and PA DOH

Objective 1: Increase the capacity of the HIV workforce to provide quality services.

Objective 2: Support efforts of funded providers to diversify their HIV workforce.

Treat

Goal 1: By 2026 95% of PLWH will be virally suppressed

Objective 1: Increase Uptake of Antiretroviral Therapy by XX % .

Objective 2: Re-engage 95% of PLWH out of care in HIV medical care.

Objective 3: Assess the needs of people aging with HIV in the jurisdiction, including long-term survivors and more recently diagnosed PLWH over 50 and identify and implement strategies to support identified needs.

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Goal 2: Increase engagement in HIV medical care to 95% among PLWH

Objective 1: Address social and structural influencers of health to reduce barriers to engagement in care for PLWDH who seek behavioral health care, housing, and supportive services.

Objective 2: Provide public-facing information on the availability of HIV treatment and supportive services for PLWH.

Goal 3: Reduce HIV-Related Disparities in HIV Outcomes

Objective 1: Address health equity disparities in Ryan White funded HIV care facilities.

Objective 2: Expand the evaluation of HIV care programs to reduce health disparities.

Objective 3: Provide training related to health equity issues and key populations to all subrecipients.

Prevent

Goal 1: Use biomedical prevention strategies to reduce new HIV diagnoses by 75%

Objective 1: 50% of people with a PrEP indication will be prescribed PrEP.

Objective 2: Ensure reliable 24/7 access to nPEP.

Objective 3: Support Perinatal Prevention Services for pregnant individuals.

Goal 2: Increasing the number of access points for evidence-based harm reduction services

Objective 1: Expand access to harm reduction supplies through novel approaches.

Objective 2: Improve SSP service delivery.

Goal 3: Reduce disparities in HIV-related prevention services in priority populations

Objective 1: Monitor local disparities along the Status-neutral Continuum.

Objective 2: Reduce HIV-related disparities in new diagnoses among priority populations.

Objective 3: Increase and support health promotion activities for HIV prevention in the communities where HIV is most heavily concentrated.

PHILADELPHIA EMA INTEGRATED PLAN 2022-2026

Respond

Goal 1: Identify and investigate active HIV transmission clusters and respond to all HIV outbreaks

Objective 1: Maintain a robust core HIV public health data system to identify outbreaks of HIV.

Objective 2: Maintain outbreak response plans and structures to respond to outbreaks and clusters that require an escalated response.

Objective 3: Intervene in all clusters that are identified.

Goal 2: Ensure data sharing with the PA and NJ Departments of Health

Objective 1: Expand data sharing with PA.

Objective 2: Implement data sharing with NJ.