MEETING AGENDA

VIRTUAL:
Thursday, January 12, 2023
2:00p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(December 8, 2022)*
- Report of Co-Chairs
- Report of Staff
- Presentation:
  - Viral Hepatitis Program
  - Clearing House/Coordinated Entry
- Committee Reports
  - *Executive Committee*
  - *Finance Committee*
  - *Nominations Committee*
  - *Positive Committee*
  - *Comprehensive Planning Committee*
  - *Prevention Committee*
- Other Business
- Announcements
- Adjournment

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

The next HIPC meeting is

VIRTUAL: February 9, 2023 from 2:00 – 4:30 p.m.

HIV Integrated Planning Council

VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, December 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, Debra D'Alessandro, Lupe Diaz (Co-Chair), Alan Edelstein, Pamela Gorman, Gus Grannan, Jeffery Haskins, Julie Hazzard, Sharee Heaven (Co-Chair), Janice Horan, Diamond Jack, Lorett Matus, Shane Nieves, Erica Rand, AJ Scruggs, Clint Steib, Evan Thornburg (Co-Chair), Adam Williams

Guests: Zachary Pierre, Mike Valetin (AACO), Ameenah McCann-Woods (AACO)

Staff: Beth Celeste, Tiffany Dominique, Debbie Law, Sofia Moletteri, Mari Ross-Russell, Kevin Trinh

Call to Order: L. Diaz called the meeting to order at 2:04 p.m. She welcomed everyone and asked them to introduce themselves in the chat box with name, county they are represented, and what they were looking forward to during the holidays.

Approval of Agenda:
L. Diaz presented the December 2022 Planning Council agenda for approval. **Motion:** M. Cappuccilli made a motion to approve the December 2022 agenda, J. Hazzard seconded to approve the amended agenda. **Motion passed:** 9 in favor, 2 abstaining.

Approval of Minutes (*November 10, 2022*)
S. Heaven presented the November 2022 meeting minutes for approval. L. Diaz said that S. Heaven had made the motion to adjourn this meeting. **Motion:** C. Steib motioned to approve the amended November 2022 meeting minutes, A. Williams seconded. **Motion passed:** 12 in favor, 4 abstaining.

Report of Co-Chairs:

No report.

Report of Staff:

M. Ross-Russell said that, as reported last meeting, the data entry for the 2022 Consumer Survey was finalized and sent for preliminary analysis to AACO. They had received some of the tables back, so OHP would be present the preliminary findings to CPC.

M. Ross-Russell reported that they now had two new OHP staff. K. Trinh was working as the CPSC (Community Planning Support Coordinator) who would support S. Moletteri. T. Dominique would be the Health Planner/Website Coordinator. They were now fully staffed, so they would hopefully be able to dig further into work.

D. Law reported that all new members were approved and had or would be receiving their letters from the mayor. She suggested new members wave their hand in the chat or introduce themselves in some other way if they cared to.

Presentation:

—2Q Spending Report—

A. McCann-Woods greeted everyone and said she would now present on the FY2022-2023 2Q (Second Quarter) Spending report. This report was the reconciliation of total invoices forwarded to AACO for processing through August 31, 2022. It indicated 13% or $1,510,253 underspending of the total award, including MAI funds.

She noted that expenditures through the 2Q demonstrated increased underspending due to late conformance of contracts, delayed approvals of programmatic budgets, delayed invoicing, and cumbersome fiscal processes inherent with the two fiduciary entities and large hospital sites. However, underspending would likely improve as the Recipient continued to receive invoices through the end of the contract period.

A. McCann-Woods first looked over the Philadelphia underspending, noting that the spending reports now contained percentages of the balance, showing how much of the total awarded amount for each service category was under or overspent.

Outpatient Ambulatory Care was underspent by $311,988 or 13% due to late invoicing and leveraging other funding sources. MCM (Medical Case Management) was underspent by $502,640 or 25% due to turnover/vacancies and late invoicing. Drug Reimbursement (LPAP) was underspent by $212,079 or 88% due to late invoicing. Mental Health Services was underspent by $36,139 or 22% due to vacancies, late invoicing, and leveraging other funding. EFA-Pharma was underspent by $56,135 or 50% specifically due to decreased utilizations. She noted that SPBP (Special Pharmaceutical Benefits Program) continued to be a great resource in getting clients access to medications quickly. Lastly, Transportation was underspent by $3,873 or 65% due to late invoicing. She was sure to mention to the group that the Recipient was aware that utilization had increased under Transportation.

A. McCann-Woods moved along to overspending for Philadelphia. The following services were overspent due to higher utilization: EFA ($23,779 or 100%), EFA-Housing ($43,372 or 17%), Food Bank ($41,408 or 40%), and Housing Assistance ($62,729 or 24%). For Food Bank, she noted that there was increased cost of food supplies. Additionally, some providers had increased access for Food Bank, e.g. family size increase or additional visits allowed per month. As for Housing Assistance, people needed longer stays since the cost of living had increased.

A. McCann-Woods next reviewed underspending in the PA Counties. There was only underspending under EFA-Pharma which was underspent by $50,123 or 56%. The reason for underspending in this service category was the same as Philadelphia: decreased utilization due to SPBP's efficiency.

As for overspending, A. McCann-Woods reported overspending in EFA ($7,181 or 60%), Food Bank ($36,130 or 100%), and Housing Assistance ($15,431 or 77%) all due to higher utilizations. As with Philadelphia, there was the increased cost of food supplies and increased cost of living which called for longer stays in transitional housing.

A. McCann-Woods next looked at the underspending for NJ Counties. MCM was underspent by $45,046 or 21% due to vacancies and late invoicing. Mental Health was underspent by $14,185 due to vacancies, late invoicing, and leveraging other funding. Substance Abuse Treatment (Outpatient) was underspent by $14,780 or 15% due to vacancies, late invoicing, and leveraging other funding (for the same reasons as Mental Health). EFA-Housing was underspent by $53,723 or 100% due to late invoicing. Lastly, Food Bank was underspent by $27,437 or 100% due to late invoicing.

As for overspending in NJ Counties, Transportation was overspent by $63,893 or 77% due to higher utilization.

A. McCann-Woods reported on spending for the Systemwide Allocation. There was underspending in I&R, QM, Capacity Building, PC Support, and Grantee Administration—this was all due to vacancies/staff turnover at AACO or OHP. She reminded everyone that any underspending below the line would be moved above the line for reallocation to direct service categories. This summed up all underspending over the line. She explained that the 56% overspending in Systemwide Coordination was a fiscal database error which was being addressed internally. The funding for this category was typically on track with spending.

—HIV Low Health Literacy Guide—

E. Thornburg introduced themselves as the Health Equity Advisor at AACO and the HIPC Governmental Co-Chair. They wanted to introduce one of the new practices AACO was executing with their providers. It was important to share with HIPC since this was an important endeavor regarding equity since many marginalized groups or vulnerable populations struggled with health literacy.

They said that this endeavor was funded under EHE. The Health Literacy Guide related to EHE because it was one of the greatest connectors to risk. Poverty was one of the leading risk factors for HIV seroconversion, so it was important to enact measures to ensure health equity.

E. Thornburg looked at the slide with “Health Literacy” written at the bottom. They explained that the average reading comprehension level of the population in the US was between a 5th – 8th grade level. Where poverty was higher and/or the population had a higher percentage of youth (people under the age of 21), that average comprehension level could be as low as 3rd grade. In Philadelphia, this was true, and post-pandemic, almost

They explained that individuals could have high literacy overall and still experience low health literacy. This was important, because those with higher education were not necessarily literate in health literacy. Health literacy improvements was the easiest systemic issue to address that

benefited everyone, not just one group or population. It was best for everyone's behavior and practices.

They explained that poverty greatly impacted health literacy, with uninsured and publicly insured individuals being the highest risk for having low health literacy. These individuals ended up having the highest medical costs, since they often utilized emergent care (people struggling with poverty tended to access medical care at a later stage of a medical concern).

Medical information (prescriptions, diagnosis, resources, etc.) were written on average at a 12th grade level. This gave an idea of the disparity of the materials people were receiving versus actual level of comprehension ability.

Overall, literacy was impacted by multiple factors; education, language of origin, sight, hearing, comprehension ability/disability, emotion, and processing capacity. Regarding emotion, this was a huge factor with impacting literacy, because duress impacted comprehension in the moment. Therefore, they wanted to help people gain understanding during one of their most emotionally heightened times. This would help people connect to information and services.

Lastly, cultural beliefs also impacted communication between providers and patients, having strong effects on a patient's ability and interest in adhering to a provider's instructions. A lot of time, people enduring low literacy found their decision making in other spaces, e.g. religious or cultural entities. These religious or cultural leaders may not be more health literate, but they were still seen as a leader that could make mass decisions and help form public opinion. Therefore, the health literacy guide could be used with community/religious leaders as well.

On the next slide, E. Thornburg asked someone to read the paragraph which contained jumbled words. A. Williams read the paragraph with some assistance from the group. E. Thornburg noted that the words were backwards instead of scrambled. The reason they did this was to represent how the words were recognizable though not fully comprehensible in their meanings. This demonstrated what health literacy could look or feel like if someone was having comprehension difficulties. If anyone had issues with identifying a word, they could miss very key information. It could be embarrassing for people to explain that they may not understand a portion of medical information.

A. Williams mentioned that for translated materials within health centers into someone's first language (other than English) had to acknowledge that direct translations did not necessarily mean health literacy. E. Thornburg agreed, saying that resource materials that contained medicalized terminology did not help with health literacy, no matter the language. 5th grade literacy levels were usually the most consumable for everyone – if providers started to go lower, such as 3rd grade level, it might start to sound condescending.

E. Thornburg added that the translators also need to be considered – it might be better to have translators with the language as their language of origin instead of a translator that learned the language later and might sound "stiff." Translations may also change geographically for each language. L. Diaz agreed, saying that cultural competency/knowledge was very important when translating as well. For example, she knew that Central American Spanish could be very different

from other regions. E. Thornburg agreed, saying there was cross exchange between countries, but translations could differ greatly—especially with nouns—between countries.

A. Williams said that asking people about their origin might not always be received well, especially depending on who the translator was. He suggested ensuring a translation was correct/well understood by setting the expectation that they would stop each other when they did not understand a word because of language barrier.

E. Thornburg moved on to the next slide, explaining that the next elements of health literacy were often separated, but they decided to keep them together. These two were Numeracy and Technology (specifically digital literacy) and both impacted clinical spaces greatly.

Explaining or laying out the application of numbers was essential. For example, explaining viral load or blood pressure is vital and whether a higher number is good or a lower number, what the ranges are, etc. Just listing numbers, such as blood pressure, could become very complex. Not explaining numbers could affect how a patient understands their individual responsibility and health management. For example, with diabetes care, saying that people could not consume more than 36 grams of carbs in each meal may not be well understood. Patients should be taught/explained what type of math they needed to do and when.

E. Thornburg said, regarding virtual spaces, low digital literacy was marginalizing people. It was helping some and hurting others, and providers needed to rely not solely on digital processes. For example, a provider that required setting up an appointment or refilling a prescription through a portal—or even scanning a QR code to check in—was inaccessible for people with low digital literacy or even a lack of the technology needed for such processes. People who wanted telehealth should be able to access it, but this did not mean cutting in-person hours.

Digital processes and portals also often required a English, but over 22% of the population in Philadelphia used a language other than English at home, so 1 in 5 patients most likely preferred to navigate the world in a language other than English.

E. Thornburg moved onto the next slide, titled Health Disparities for Low Health Literacy. They explained that 12% of Americans had proficient health literacy. This meant most of the population could benefit from low health literacy best practices. Limited health literacy affected all racial/ethnic groups but was disproportionate across them. For a further understanding of how it affected such groups, 28% of white adults had between basic—below basic literacy while 65% of Latinx adults fell within this range. They noted that this was a national number.

E. Thornburg said that approximately 1 in 3 people with a graduate degree could fully understand medical information provided to them – this was not necessarily linked to their furthered education so much as it was their "social stratification." People with graduate degrees often had more access to improvised conversations with others better explaining medical care or terminology—e.g. more connections to people working in the medical care field.

E. Thornburg continued, explaining that numeracy and technological adaptability were separate from but compound health literacy. Therefore, someone with strong health literacy could still

have trouble navigating digital platforms, thus dropping health literacy exponentially. Adults over 65 were the group more impacted by health literacy due to compounding factors like sight, hearing, comprehension due to aging, technology, etc. Technology moved quickly which often left people behind. Lastly, E. Thornburg said low health literacy resulted in patients paying more on average in health care costs and increased visits to the ER, hospital admission, and decreased access to appropriate care.

As for quick best practices, E. Thornburg said having pictures or images readily available, whether drawn on the spot or pre-prepared, was important. This was because pictures could often be universal. Choosing color with intention was important so that people with color perception limits—this meant avoiding colors that blended out or avoiding over-texturizing. Bolding and larger font sizes was also important. As for digital resources, using alt-text was important so screen readers could read them. Screen readers would be able to read PDFs but not JPEGs.

Limiting numbers and data as well as simplifying information could only be helpful. Rhymes and other "memory tricks help things stick." This was why those with Alzheimer's could remember songs—lyrics usually rhymed. Music and rhymes had important staying power.

E. Thornburg next looked at the slide titled HIV Low Health Literacy Guide. They explained that the guide greatly impacted consumers' ability to make decisions regarding their care, their consistency with care and medication adherence, and any necessary behavior adjustments. The guide was a collected set of standard best practices for clinical spaces to provide resources, diagnoses, case management, prescriptions, and care at a more universal literacy range for all consumers to best understand.

Within the guide, there was: (1) a quick HIV specific literacy, numeracy, and color perception test that could be given by any clinician, (2) standards for print and digital resource materials, and (3) standards for verbal communication.

AACO also had a 1/1.5-hour training that taught case managers and clinicians how to utilize the guide and what low literacy looked like. Today's meeting was a very small portion of what the total training entailed. The guide was sharable, but E. Thornburg asked that they use the citation on the front to give credit to AACO.

E. Thornburg said that the guide produced by AACO and was HIV-synonyms. The guide was consumed at a 6th grade reading level.

G. Grannan pointed out that communication was a two-way process, and breakdown could happen on clinician and patient sides. Therefore, clinicians needed to ensure that they were keeping tabs on what the patient was hearing. For example, while he was working on a material, it used "Buprenorphine" even though those outside of the clinical context might not know what it was. E. Thornburg said that there was a training that focused on distributing the guide—the training a lot of systems-level conversations and real-life examples. The training and receiving the guide was a requisite for individuals providing information. This was why the guide's first section was about tailoring verbal communication.

Committee Reports:

—Executive Committee—
No report.

—Finance Committee—

A. Edelstein reported that Dr. Obiri's follow-up letter, as discussed in last month's HIPC meeting, was a discussion item during this past Finance Committee meeting. He reminded everyone that while performing allocations during the summer, HIPC saw a discrepancy in the reported numbers for PLWH in the PA Counties. There was a difference of about 500 PLWH. Therefore, Finance Committee sent a letter to Dr. Obiri asking for an explanation. After receiving a response from Dr. Obiri, the Finance Committee arrived at the conclusion that the letter was not very responsive to HIPC's concerns. A. Edelstein reported that Dr. Brady was working on her own response, so they were waiting to see what Dr. Brady had to say which would hopefully bring clarity. Afterwards, they could write their own letter to Dr. Obiri if they so desired, but Dr. Brady would go first.

They were hoping to have some resolution by next month.

—Nominations Committee—

M. Cappuccilli reported that the Nominations Committee met today, right before this meeting. They had 15 new and returning members that were approved, so HIPC now had a total of 38 members. They also discussed bylaws, membership, recruitment, and retention. They were going to return to this discussion with more set ideas next meeting. They wanted their membership to be well above 35 individuals.

The group also discussed barriers to application process, specifically the tax clearance which was unfortunately out of their control.

They also discussed virtual meetings as a barrier to engagement and how hybrid was now under discussion.

Lastly, the committee discussed orientation for new members and how to increase engagement. Some ideas included having more participation Nominations Committee members like how it was in-person as well as Zoom breakout rooms. Another idea was to have orientation before a shorter HIPC meeting. Orientation could continue after the HIPC meeting to help debrief their first meeting.

—Positive Committee—

S. Moletteri reported that Poz Committee reviewed the new TelePrEP portion of the phillykeeponloving website and made some recommendations. They also discussed housing as a barrier to prevention and care within Philadelphia and the suburban counties.

—Comprehensive Planning Committee—

G. Grannan reported that during the last meeting, CPC focused on concurrence with the 2022-2026 Integrated Plan. They had ultimately concurred with the plan.

—Prevention Committee—

C. Steib reported that Prevention Committee would not meet in December due to the holidays.

Other Business:

None.

Announcements:

D. Law said that new members could feel free to stay a bit after the meeting if they had any questions.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** C. Steib motioned, L. Matus seconded. Meeting adjourned 3:21 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- December 2022 HIPC Meeting Agenda
- November 2022 HIPC Meeting Minutes