Comprehensive Planning Committee
Meeting Minutes of
Thursday, February 16th, 2023
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Michael Cappuccilli, Keith Carter, Debra D'Alessandro, Lupe Diaz, Gus Grannan, Gerry Keys, Adam Williams

Guest: Sanzida Anzuman, Rene Cirillo (DHST), Blake Rowley

Excused: Clint Steib

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

Call to Order: G. Grannan called the meeting to order at 2:02 pm.

Introductions: G. Grannan asked everyone to introduce themselves.

Approval of Agenda:

G. Grannan referred to the February 2023 Comprehensive Planning Council agenda and asked for a motion to approve. **Motion:** K. Cater motioned; L. Diaz seconded to approve the February Comprehensive Planning Committee agenda. **Motion passed:** 6 in favor. 1 abstaining. The February 2023 agenda was approved.

Approval of Minutes (*January 19th, 2022*):

G. Grannan referred to the January 2023 Comprehensive Planning Committee minutes. **Motion:** G. Keys motioned; K. Carter seconded to approve the January 2023 meeting minutes and Agenda via a Zoom poll. **Motion passed:** 4 in favor. 2 abstaining. The January 2023 Minutes are approved.

Report of Co-chairs

G. Grannan did not have a report.

Report of Staff

M. Ross-Russell said there would be an Executive Committee meeting in the future to resolve the issue with the State of PA's prevalence data.

S. Moletteri reported that she had emailed a poll for possible dates for the Executive Committee meeting. The poll showed that the Executive meeting members preferred February 24th, 2023 as the meeting date. L. Diaz asked what time the meeting would take place on that day. S. Moletteri said they did not include the option to choose a time on the poll but they were open to suggestions. K. Carter and M. Ross-Russell said they had conflicts with another meeting but were willing to move back their meeting. The rest of the committee did not have scheduling conflicts.

Presentation:

–Transportation by the Division of HIV, STD, and TB services–

R. Cirillo introduced herself as the Program Operations Manager at the New Jersey Division of HIV, STD, and TB (DHST). She gave an overview of the DHST services. She said the organization's goal is to prevent and treat HIV as well as provide resources for people who need them. The Division resources help community-based networks deliver the services that meet the language and cultural needs of the people they serve. R. Cirillo's Department oversees the grant funding in NJ such as state, CDC, and Ryan White funding.

R. Cirillo displayed a chart detailing NJ's Ryan White Part B (RWB) funded transportation services. The funds were awarded to agencies that served a certain area. For example, Atlanticare serves Atlantic County and ARFC serves Essex county. R. Cirillo said there were transportation services for women suffering from domestic violence. R. Cirillo pointed out that each county had a different mode of transportation that they lent to their clients. The chart also includes Ryan White Supplemental (RWS) for Essex County which provides housing for People Living With HIV (PLWH) who experienced domestic violence or sexual abuse. The funding cycle for RWS was from September to August. The funding cycle for RWB was from April to March of the following year.

R. Cirillo said she would get to this information soon. Cooper Health, Rutgers DAYAM, and Kennedy University Hospital were state-funded for their services in Camden, Essex County, and Burlington. R. Cirillo said that certain counties such as Essex County had funding from multiple sources including federal and state funding.

In the next slide, R. Cirillo reviewed the South Jersey RWB agency expenditures as of 12/13/22. She said this information was based on the South Jersey RWB Agency quarterly reporting. Because of this, R. Cirillo wanted to preface that the expenditure information in the presentation was not up to date. She then defined the area of South Jersey as Atlantic, Burlington, Cape, Cumberland, Gloucester, Salem, and Ocean Counties. The chart showed that Ocean BSS had expended $14,315 or 42% of their $24,500 budget. The AtlantiCare agency had spent 0% of its $5,880 budget. The South Jersey AIDS Alliance (SJAA) agency spent $20,841 or 67% of its $31,333 budget. The SJAA Minority AIDS Initiative (MAI) agency had spent $20, 841 or 67% of its $31,333 budget. R. Cirillo noted that the information regarding AtlantiCare expenditures may be incorrect because they do not have the most recent information.

R. Cirillo then reviewed the South Jersey State Funded Agency expenditures. She said Cooper had expended $11, 051 or 71% of their $15, 569 budget, and Kennedy had spent $3,932, or 47% of their $8, 376 budget. R. Cirillo added that she did not have the second quarter expenditures for Cooper and only had the expenditures from October 1st, 2022. She expected that the agencies had spent down the funding.

The presentation had concluded and R. Cirillo opened the presentation to questions from the audience. M. Cappuccilli asked how the funding source was decided for each service. R. Cirillo explained that the funding for each service was decided on the county the individual was looking to find transportation. She said the goal of each agency was to provide service without much hassle to the individual. She added that the state-funded services were exceptional in that they provide service to individuals regardless of their HIV status. If a person was HIV negative, they aimed to keep the person HIV negative.

K. Carter asked if funding was affected by the location of the client. He then asked if the local agency could not fund the service, another agency would fund the service. R. Cirillo said she had not viewed the issue from that perspective and had viewed the issue from a customer-lead perspective. She said that they adapted their services to ensure that the clients were able to use their services.

M. Cappuccilli asked R. Cirillo to list the types of reimbursements for Ryan White Part A (RWA). R. Cirillo said that RWA was not part of her division and she could look into this topic with her division's RWA partners if M. Cappuccilli was interested. M. Cappuccilli said he was curious if RWA reimbursements were just as varied as RWB.

R. Cirillo mentioned that she had known a site that catered to the client's needs uniquely. If a client was in Philadelphia and needed a means of transport to another county, the site person would either go with the person to the location or take the trip by themselves to see if the trip was feasible for the client. R. Cirillo said this was one way to handle transportation deserts.

K. Carter asked if the agencies would use their own vehicles to transport the clients. R. Cirillo said the agencies would sometimes have their own transportation.

M. Cappuccilli asked if R. Cirillo had seen transportation usage trends over the years. R. Cirillo said more people had been using more Uber rides, except in South Jersey. R. Cirillo attributed low Uber usage in South Jersey to low demand. She explained that South Jersey is sparse and has more sprawl than other areas. Uber drivers were independent contractors. If there was little demand, Uber drivers were not incentivized to work in that area.

M. Cappuccilli asked what service can sustain in a sparse area. R. Cirillo said the Board of Social Services contract private taxi companies.

S. Moletteri asked about the effectiveness of public transportation in South Jersey or if people simply preferred taxi services. R. Cirillo replied that people preferred taxi services. She said

public transportation did not exist in some areas and it would depend on what transportation services are available. K. Carter added that bus stops in South Jersey could be miles apart from one another. R. Cirillo said AtlantiCare or SJAA had their vehicles stationed in three different counties.

M. Ross-Russell asked if there is an issue if the person had to cross county lines using the services. R. Cirillo said it was not an issue, but it could be a barrier due to territory and funding disputes.

K. Carter asked if there was any underspending due to client demand. R. Cirillo said there was hesitation during COVID when people were asked to share vehicles. She had expected there would be underspending, but clients still want to use the services.

M. Cappuccilli asked R. Cirillo to define care from the perspective of the state of NJ. R. Cirillo says NJ approaches care from a status-neutral position. Once someone had been tested for HIV, the type of care would be defined by the result. This could be preventative care or it could be HIV treatment. RWB has restrictions on how transportation funding can be utilized. Specifically, RWB intends transportation to be used for medical emergencies and medical services. R. Cirillo said that state funding is less restrictive than RWB and encouraged agencies to use state funding if they were worried about their RWB funding.

S. Moletteri asked if it was the agency's decision if they were to go beyond county lines. R. Cirillo confirmed that was the agency's choice until it becomes a barrier to providing service. Once the decision has become a barrier to care, it no longer aligns with the state's goals and the state would have to intervene.

Discussion Items:

-PA State Plan-

S. Moletteri led the PA State Plan discussion. She reviewed the PA State Plan and the Philadelphia EMA Integrated Plan and compared both plans, concluding that the plans were very similar. For example, both plans emphasized collaboration.

Both plans followed the End the Epidemic Plan (EHE) pillars. The pillars were "prevent, diagnose, treat, and respond to HIV." The difference between the two plans was the order of the pillars. For example, the PA State Plan had "Prevent" as the first pillar while Philadelphia EMA Integrated Plan had the pillar as third. Both plans had a "bonus" pillar which differed from each other. The PA State Plan has "Support" as a bonus pillar while the Philadelphia EMA Integrated Plan has "Develop" as its bonus pillar. S. Moletteri concluded that the PA State Plan's bonus pillar was more substantial.

The first pillar for PA State Plan was "Prevent." Both plans had an emphasis on expanding Pre-exposure prophylaxis (PrEP). Both plans had also included training for prescribing PrEP.

The difference between the PA State Plan and the Philadelphia EMA Integrated Plan was that the PA State Plan sought to increase PrEP linkage by 50%. The Philadelphia EMA Integrated Plan has the goal of prescribing PrEP to 50% of those with an indication of HIV.

Both plans have perinatal care as an objective. Both plans also have support for Syringe Service Programs (SSP). However, the Philadelphia EMA Integrated Plan goes into more detail about harm reduction programs and mentions access to syringes and harm reduction vending machines.

K. Carter asked S. Moletteri to provide more information about the plans' perinatal objectives. S. Moletteri said that Philadelphia EMA's Integrated Plan aimed to provide special case management for pregnant persons living with HIV, develop PrEP navigation support for pregnant HIV-negative women at risk of HIV acquisition, conduct case surveillance for women with diagnosed HIV infection and their infants, and conduct perinatal HIV exposure reporting. S. Moletteri concluded after reviewing the Integrated Plan that the PA State Plan had similar goals.

K. Carter said he believed that he had not heard of any recent reports of perinatal transmission. S. Moletteri believed the recent number of reports was 0 and attributed the low number to the prevention efforts such as the Philadelphia Integrated Plan. K. Carter added that the transmission between parent and child was called a vertical transmission and the parent should not be blamed for the transmission.

The PA State Plan Prevention objectives were also different in that they focused on re-engaging those who were lost to care. In comparison, the Philadelphia Integrated Plan views the re-engagement of those lost to care as a Treat goal rather than a Prevent goal. The Philadelphia Integrated Plan focuses more on expanding operating hours and evaluating more MCMs (Medical Case Managers) and community workers on Ryan White sites. S. Moletteri said this was called "managed problem-solving."

A. Williams said he would be interested in learning more about the vending machines mentioned previously. S. Moletteri said they would be discussing the vending machines soon. She said that the vending machine contents would depend on the location. For example, a school could have condoms in its vending machine.

M. Ross-Russell said they were waiting for a list of vending machine locations and a list of their contents. She said there were 4 vending machines in Philadelphia prisons. M. Ross-Russell said the vending machines should have items such as fentanyl strips, syringes, and other harm-reduction items. However, she acknowledged that these items would not be allowed in jail. D. D'Alessandro said the vending machine gives the products for free.

D. D'Alessandro asked S. Moletteri if the re-engagement for those lost to care was during the PrEP stage or if it was all stages of care. S. Moletteri said that while the PA State Plan focused on providing status-neutral care, this objective focused on helping those who were PLWH.

G. Grannan asked if there was a requirement to return used supplies for the vending machines. D. D'Alessandro said she did not hear about the Philadelphia Health Department specifying this as a requirement. G. Grannan said this was a requirement before and he had wanted to confirm that it was not the case anymore, D'Alessandro said she could not confirm this was true for the state but she could confirm that Philadelphia does not have this requirement. K. Carter asked if drug stores such as CVS had syringes that individuals could purchase. G. Grannan said this would only be the case in an ideal world.

S. Moletteri said the PA State Plan had a greater emphasis on condom distribution as a prevention tool while the Philadelphia Integrated Plan only had condom distribution as a treatment goal.

S. Moletteri said the PA State Plan was working on creating a Status Neutral Navigation and Linkage (SNNLS) plan. S. Moletteri added that she had attended an HIV Planning Group (HPG) and confirmed that the PA state was still working on the plan. S. Moletteri said the Philadelphia Integrated Plan does mention this topic but was not as in-depth as the PA State Plan.

The PA State Plan also planned to have a social media campaign to reduce stigma and bring awareness about HIV prevention and treatment through educational material. S. Moletteri said that the Philadelphia EMA Integrated Plan did have an objective to bring awareness through educational materials. S. Moletteri added that they were aware of a digital divide where certain members of their stakeholders could not use or access the computer. To fix this issue, S. Moletteri said the Philadelphia EMA had also distributed physical handouts of the educational material.

K. Carter asked how providers were getting informed about PrEP. He said that if providers did not know or were biased toward PrEP, they would not prescribe PrEP to their patients. S. Moletteri said that was a valid point and said that PhillyKeepOnLoving had an awareness campaign to inform the public about PrEP. S. Moletteri said that the Philadelphia Integrated Plan had a training section for providers.

A. Williams said there was a certain number of doctors or medical providers who knew about PrEP. Of this group of people, A. Williams said that these providers could be biased towards PrEP due to the medical training that had ingrained a hesitancy around prescribing antiretrovirals. A. Williams said they were previously advised against antiretrovirals because they had harsher side effects in the past. However, the new antiretrovirals were more manageable. This becomes a problem because patients would have to list their PrEP provider as their primary care provider. Patients faced with the choice to switch providers or continue with a doctor who would not prescribe PrEP. The patients would often choose to not take PrEP.

G. Grannan said he believed this was a policy as well as an insurance issue. A. Williams agreed and added that insurance reimbursements to health centers run into hurdles if the primary care provider does not approve. As a result, patients had to list the health center as the primary care provider. G. Keys said this would be taking away service from people who would not be eligible

for other medical insurance. They added that patients would need medical information that they would not get from their primary provider. A. Williams said that the health centers do perform medical tests to obtain the patient's medical history. He then acknowledged that it was a barrier to care.

M. Cappuccilli asked what was the standard PrEP procedure for care and if the follow-up appointments could be coordinated with another provider. A. Williams said the protocol was to have the patient return every three months to have a check-up to ensure they were healthy enough to continue PrEP as well as treat any STD they have encountered in between.

G. Keys had agreed and said there was a dissonance between the providers who gave PrEP and the primary care doctors. K. Carter said it was strange that doctors generally refer to specialists for other medical problems. For example, if someone had a kidney problem, the primary care doctor would refer that person to a kidney specialist. G. Keys said the problem was that a primary care doctor could not refer to another primary care provider.

T. Dominque thanked the committee for being passionate about this topic and asked them to table this discussion for the Prevention Committee meeting.

S. Moletteri continued with their presentation. The next pillar was Diagnose. S. Moletteri said both plans had wanted to expand self-testing coordination in non-clinical testing. Both plans have a focus on priority populations. S. Moletteri did not have a list of the priority populations but said they would send a PDF of the plans to the committee afterward. Both plans have a focus on syndemics and examining viral hepatitis testing and substance use disorder. Both plans had also a focus on iART or Immediate ART. S. Moletteri said the goal of the Philadelphia EMA Integrated Plan was to increase the ART uptake of newly diagnosed HIV-positive patients to 95%. The PA State Plan aimed to add early initiation language to their provider agreements.

The difference between the plans was that the Philadelphia EMA Integrated Plan aimed to increase opt-out testing while the PA State Plan did not mention this.

The next pillar was Treat. Both plans strived to have improved engagement in supportive services as a way to treat people. The difference between the two plans in this section was that the Philadelphia EMA Integrated Plan mentions which programs and services need increased engagement as well as which models could achieve those goals. The PA State Plan does not mention this.

The second similarity between the two plans in treatment goals was to increase retention in care and improve viral load suppression. The other difference between the two plans was that the PA State Plan sought to enhance a Clinical Quality Management (CQM) plan. PA State had said they would be continuing their work with SPBP and MAI. The Philadelphia EMA Integrated Plan sought to re-engage those who were lost to care, reduce health disparities, provide information bridging the digital divide, and assess aging PWLH.

S. Moletteri said the 4th pillar was Respond. Both plans had an Outbreak Response Plan (ORPs). They both aimed to have a plan of action within 72 hours of an outbreak declaration. The ORP was required to have a summary, report, and evaluation to improve their response. Both plans also sought to enhance surveillance and data management.

The Philadelphia Integrated Plan had a greater focus on data sharing while the PA State Plan aimed to create a dashboard to monitor data and trends of HIV transmission.

The next pillar was the "extra" pillar. In the Philadelphia EMA Integrated Plan, this was called the Support pillar while the PA State Plan calls it the Develop pillar. The idea was that this pillar would support the other pillars mentioned above. This extra pillar had training for more improved customer service and person-centered language. It also focuses on capacity-building training and technical assistance. In this pillar, the PA State Plan focuses on the earlier mentioned activities in the Philadelphia EMA Integrated plan such as culturally competent messaging, supporting aging PWLH, MCM, and trauma-informed care. The PA State Plan also aimed to monitor legislative language regarding HIV and assess training needs. The Philadelphia EMA Integrated Plan had a goal to diversify its HIV workforce.

K. Carter asked how the PA State Plan had measured the effectiveness of their radical-customer-service training program. T. Dominque offered to send the question to J. Williams from the DHH (Division of HIV Health).

T. Dominque asked if they could include the NJ Integrated Plan for comparison. M. Ross-Russell said that NJ Plan had more differences than the other two plans. L. Diaz asked if the committee could be sent a copy of the NJ Integrated Plan.

K. Carter asked why NJ had a singular plan while Pennsylvania had multiple plans. M. Ross-Russell said that it was because the guidance policy from the federal government said they had to have a statewide plan. In Pennsylvania, they had the option to do an individual plan. Philadelphia had created its own individual plan because it had crossed two state lines.

S. Moletteri asked how the committee would like the NJ Integrated Plan to be sent to them. The committee agreed that they could be emailed the plan.

Any Other Business:

K. Carter asked when they would be able to meet in person. M. Ross-Russell said she did not have a timeline yet. M. Ross-Russell said that since policies at the federal level were changing, it's possible that in-person meetings could happen in May 2023.

Announcements:

None

Adjournment:

G. Grannan called for a motion to adjourn. **Motion:** L. Diaz motioned, and K. Carter seconded to adjourn the Comprehensive Planning Committee meeting. **Motion passed:** Meeting adjourned at 3:39 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- February 2023 Meeting Agenda
- January 2023 Meeting Minutes
- PA State Plan Vs. Integrated Plan (PDF)
- Pennsylvania State Plan & Philadelphia EMA Integrated Plan presentation slide show (PDF)
- New Jersey Integrated HIV Prevention and Care Plan Including the Statewide Coordinated Statement of Need, CY 2022-2026 (PDF)