Meeting Agenda

VIRTUAL:
Wednesday, May 24th, 2023
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes
  - Comprehensive Planning Committee (March 16, 2023)
  - Prevention Committee (April 26, 2023)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - Housing - Daiquiri Robinson
- Discussion Items
  - Generation of Allocation Recommendation Activity
- Action Item
  - Election of CPC Co-chair
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Comprehensive Planning Committee meeting is
VIRTUAL: Thursday, June 15th, 2023 from 2:00 p.m. – 4:00 p.m.

The next Prevention Committee meeting is
VIRTUAL: Wednesday, June 28th, 2023 from 2:30 p.m. – 4:30 p.m.

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
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Comprehensive Planning/Prevention Committee

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

Present: Keith Carter, Gus Grannan (Co-chair), Gerry Keys, Pamela Gorman

Guest: Sanzida Anzuman (DHH), Gita Krull-Aquila (DHH), Nina Tao

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

Call to Order: G. Grannan called the meeting to order at 2:05 pm.

Introductions: G. Grannan asked everyone to introduce themselves.

Approval of Agenda:

G. Grannan referred to the March 2023 CPC agenda and asked for a motion to approve. **Motion:** K. Carter motioned; G. Keys seconded to approve the March 2023 Comprehensive Planning Committee agenda via a Zoom poll **Motion passed:** 3 in favor. 2 abstaining. The March 2023 CPC agenda was approved.

Approval of Minutes (*February 16th, 2022*):

G. Grannan referred to the February 2023 CPC minutes. **Motion:** K. Carter motioned; G. Keys seconded to approve the February 2023 meeting minutes via a Zoom poll. **Motion passed:** 3 in favor. 2 abstaining. The February 2023 CPC Minutes were approved.

Report of Co-chairs

None.

Report of Staff

M. Ross-Russell reported that the Prevention Committee would review the maps on the Office of HIV Planning (OHP) website. S. Moletteri would send the maps to the committee in an email. She asked for feedback on what information within the maps was helpful or not helpful.

Presentation:

–Quality Management Plan–

G. Krull-Aquila from the Department of HIV Health (DHH) introduced herself and said she would continue her Quality Management Plan presentation. G. Krull-Aquila had previously presented this topic in the previous HIV Integrated Planning Council (HIPC) meeting. G. Krull-Aquila wanted to ask HIPC three discussion questions, but she could not due to time constraints. G. Krull-Aquila thanked M. Ross-Russell for inviting her back to allow her to start the discussion. G. Krull-Aquila said she had abbreviated the presentation and added more information regarding the action steps to their Quality Management (QM) Plan goals.

G. Krull-Aquila thanked S. Anzuman for her work on the QM Plan. S. Anzuman announced that she would leave the Department of Human Services (DHS) after 4 years of service. She said her final day of employment with DHS would be March 30, 2023. She thanked the committee for inviting her and appreciated working with everyone.

She gave a brief overview of the agenda. The presentation would comprise an overview of the QM Plan, followed by a QM Plan Work Plan presentation and a discussion session.

G. Krull-Aquila said the goal of the eligible metropolitan areas (EMA)'s QM was to use quality data to improve access to high-quality HIV care. She said DHH's QM program has activities spanning all aspects of the HIV care continuum. G. Krull-Aquila referred to a chart displaying the activities that made up the DHH QM Program. The DHH QM consisted of performance monitoring, quality improvement projects (QIPs), and capacity building. G. Krull-Aquila explained that performance monitoring consisted of DHH performance measure reports (PMRs) and appointment availability calls. She said that DHH would incorporate QIPs into their Medical Case Management (MCM). She said they were looking to do QIPs with their status-neutral programs. They perform technical assistance and training on performance measures.

DHH's QI principle was that the consumer defined quality. She said the Ryan White system was built on consumer contribution, participation, feedback, and advocacy. DHH hoped to increase consumer priority in the coming year for all steps of the QI process. The QM Plan was written by the QM Advisor, S. Anzuman, and the QM Coordinator, G. Krull-Aquila with input from the DHH units when needed. G. Krull-Aquila said they aimed to create a more streamlined and concise plan to release to their stakeholders in 2023. She said when she started working on the QM Plan in June 2022, it was over 80 pages long.

G. Krull-Aquila reviewed the components of the QM Plan. The components of the QM Plan were organizational summary, quality statement, quality infrastructure, annual goals and objectives, participation of stakeholders, performance measurement, capacity building, evaluation of QM program, work plan and process to update QM Plan.

She described the components of the QM work plan. She said they had to list their goals. Then they would need to list the objectives for each goal. For each goal, they would also need to create action steps to achieve each goal. Within each action step, the QM Plan would describe the specific activities, the staff responsible for each activity, and each outcome's time frame.

K. Carter asked if there should be two separate plans for the providers and the consumers. G. Krull-Aquila asked S. Moletteri if they should field questions during the presentation. S. Moletteri suggested that answering questions during the presentation would be helpful so they would not need to backtrack at the end. G. Krull-Aquila returned to K. Carter's question. She replied that they could not have two separate plans since consumer feedback was vital to the plan.

G. Krull-Aquila reviewed the goals, objectives, and action steps of the QM Plan. The first goal was to evaluate, build upon and expand clinical quality management (CQM) infrastructure and activities supporting the End the Epidemic (EHE) goals.

The first objective was to monitor and evaluate improvements in access to and initiation of status-neutral HIV treatment and care. To achieve this objective, she said DHH would gather, monitor and analyze data obtained from low-threshold HIV treatment site visits using a database called CAREWare 6. The next step would be to monitor program activities by collecting and evaluating regularly scheduled provider reports to ensure program implementation met the local EHE goals. The third action step would be to employ an outcome measure for Immediate Antiretroviral Therapy (iART) at all DHH-funded outpatient ambulatory health service (O/AHS) programs. The next action step would be identifying EMA-wide disparities in the Ryan White database by race, age risk, and insurance status.

G. Grannan asked what the term "status neutral" meant. S. Anzuman explained that "status neutral" meant that they provided service to a person regardless of their HIV test outcome. If a person had tested negative, they would be given prevention information such as pre-exposure prophylaxis (PrEP). If a person had tested positive, they would be directed towards HIV medication and therapy such as iART. The reason why they had used the term "status neutral" was because they wanted more people to get tested and know their status. G. Grannan thanked S. Anzuman for her explanation.

K. Carter noted how DHH wanted input from the community but questioned how the community would know if the issues the community had raised were addressed. He asked how they would communicate the process and action steps taken to address the problems to the community. G. Krull-Aquila said this was addressed within the Work Plan section of the presentation and would soon get to it.

G. Krull-Aquila returned to the action steps of the first goal. She said they would present the disparities at the annual QM meeting. They would then modify the public-facing EHE dashboard to present unblinded provider-specific information on viral load and retention in medical care.

G. Krull-Aquila said the second objective of goal 1 was to apply a QI perspective to review and provide feedback on Corrective Action Plans (CAPs) submitted from providers with identified issues during bi-annual DHH appointment availability calls. The first action step to achieve this goal was to conduct O/AHS appointment availability calls twice a year in English and Spanish. DHH would analyze these calls and provide feedback reports to the staff. DHH called these

“secret shopper” calls to test if a new client could schedule an appointment. The next action step would be to receive the CAP from program analysts for programs with issues and complete a CAP review form. Quality specialists would then communicate with program analysts regarding CAP and offer suggestions for resources, metrics to monitor or action step modifications as needed.

K. Carter asked if this was a site-specific action plan. G. Krull-Aquila replied that the CAP was a site-specific action plan. She described an example where a hospital could not provide a client with a timely appointment. She said the hospital would then need to complete a CAP form. QI analysts would then review the form and decide if improvements could be made to improve the service.

S. Moletteri asked if they could check the appointments' results and measure each client's satisfaction. G. Krull-Aquila said they had focused on getting the client an appointment date. She said they pay attention to the events of the call and any barriers that may block the client from receiving services. She added that they do not have a way to review what happens during an appointment. G. Krull-Aquila explained that they do not save the information once a call has been made since they want to focus on helping other people find appointments.

K. Carter asked if they had recorded the calls for quality improvement. He said if they could measure the call like other call centers, they could improve client experience. G. Krull-Aquila explained that they could not record the calls. She said there were certain parameters that they looked for when listening to calls. DHH looked at parameters such as how long it took to receive an appointment date or how long the client was put on hold. S. Anzuman said that when they listen to calls, they have a form in front of them where they document everything. She said that if an agent was rude, they would follow up with that agent. She said they document everything including good and bad interactions such as the number of transfers, the agent’s professionalism and the repertoire between agent and client. S. Aznuman clarified that her department does not record the calls but the program department of DHH did record their calls.

G. Krull-Aquila said evaluating the quality of the appointment was the provider’s responsibility. G. Keys said that while she agreed that evaluations were beneficial, she recalled from her experience that the “secret shoppers” would sometimes antagonize the staff. She said people have been paid to come in and request an HIV test. G. Keys said that once a person has requested an appointment, that record was legal whether the appointment was finalized or not. This legal record could not be deleted. G. Keys said this had caused problems while working in the ambulatory service. They had to contend with a record that was not a true appointment. K. Carter said he understood this had interfered with their records and metrics. G. Keys said they could delete the record but they could not delete the patient information and the record that an appointment was made. That person would be considered a patient of the provider.

K. Carter asked if they could have someone at the provider site to follow the “secret shopper” when they reached their appointment. He said they could observe and ensure that the quality of medical care was adequate. G. Krull-Aquila explained that they were focusing on helping a

newly diagnosed person with HIV or a person lost to care to get an appointment as easily as possible. G. Krull-Aquila said confirming the appointment was just as important as the appointment. K. Carter suggested that the "secret shopper" should bring an evaluation sheet to fill out. G. Krull-Aquila agreed that DHH should look into this idea. She said that the idea could be good to foster collaboration between DHH and providers. S. Anzuman thanked K. Carter for his idea and said it could be a way to incorporate consumer feedback.

G. Krull-Aquila referred to the third goal. The goal was to re-evaluate barriers reported by patients re-engaged in care through Field Services and incorporate results into the CQM program including provider QI projects. The first action step for this objective was to collect information on the barriers to care experienced by patients. The second action step was to develop data-to-care (DTC) feedback reports and disseminate them to participating O/AHS providers biannually. The next step would be to provide a monthly list of those who were either not in care or were not virally suppressed to HIV providers where the client last had an appointment.

G. Krull-Aquila proceeded to Goal 1 Objective 4. The objective was to initiate QIPs with DHH-funded prevention and MCM programs using the coaching model to improve performance across identified areas. The first action step was learning about prevention initiatives by training and reviewing program reports and procedures. The next step was to meet with prevention providers to learn about programs and any implementation issues. The third action step was to provide training and technical assistance to prevention programs while conducting QIPs. Then they would evaluate the prevention QIP outcomes. DHH aimed to provide introductory training to MCM providers on DHH QM, QIP process and the new coaching model. The final action step for goal 1 objective 4 was to disseminate 2023 QIP outcomes to providers, the regional CQM committee, DHH staff and relevant stakeholders.

G. Grannan asked if they had integrated the availability of training into their QIP and CAP. He said it would be unfair to providers if they were reprimanded for something they were not properly informed about. G. Krull-Aquila assured G. Grannan that they provide substantial training. She said that the first step in the coaching model was to discern the needs of each program to allow DHH to tailor their training to each provider. G. Krull-Aquila said if they could not provide the training, they would connect the provider to the resource they need.

K. Carter asked if there was a way to measure the quality of care for minorities at places such as the ER. He said many people do not have insurance and he wanted to know if there was a way to record their experiences. M. Ross-Russell said they would most likely have providers who were government funded that were generally unwilling to provide detailed information about their services. S. Anzuman agreed with M. Ross-Russell. She added that hospitals may have their own evaluation process for ER visits. She said they could not ask for ER visit information because they fund HIV care and testing. She said the hospital may have a process for ER visits.

G. Krull-Aquila reviewed goal 1 objective 5 of the QM Plan. She said objective 5 aimed to continue the collaboration between DHH Information Services Unit (ISU) and the EHE team around aligning CQM activities including updating EHE outcomes measures for EHE

re-engagement activities. The first action step was to have the QM Plan team meet the EHE team regularly to stay updated on activities and opportunities for QIPs through ISU. The next step was to participate in implementation science training to enhance coordination for EHE activities and explore ways to address provider barriers.

G. Krull-Aquila reviewed goal 2 of the QM Plan. The second goal aimed to improve the coordination between O/AHS and MCM providers to support the linkage and retention of clients in care. The first objective of the second goal aimed to continue to update and share O/AHS program contact information with MCM providers biannually to support the monitoring of treatment adherence and to improve health outcomes. The first action step was to email O/AHS providers with a contact form to complete. Then they would compile and distribute primary and secondary O/AHS contacts for MCM providers twice a year. The third objective was to create an evaluation process to measure the referral of unsuppressed O/AHS clients to MCM services. The action step to achieve this goal was to evaluate the PHL25 performance measure found in CAREWare.

The fourth objective of goal 2 was to integrate O/AHS and MCM QIPs to foster more collaboration. The action step to complete this objective was communicating and involving both O/AHS and MCM staff during QIP training and discussion. The next action step was to develop an evaluation process for new co-located QIPs. DHH would then present the QM Plan to HIPC to obtain input and feedback. Then DHH would present the QM Plan to the Positive Committee to obtain input and feedback. DHH would explore the feasibility of a biannual check-in with the Positive Committee to receive input and feedback.

G. Krull-Aquila reviewed the third goal. The third goal was to create an inclusive and streamlined QM Plan to guide QM activities. The first objective of this goal was to develop a process to obtain and incorporate consumer feedback into the DHH QM Plan on a regularly scheduled basis. The action step was to coordinate with the DHH Engagement Coordinator to obtain community input and feedback on the QM program and to align efforts with other DHH units.

The second objective of goal 3 was to work with the regional CQM committee of sub-recipients to obtain feedback on the DHH QM plan and amend as needed. The next action step was to gather the needs of each program's regional CQM Committee to obtain input on various QM topics including the QM Plan.

The third objective would connect the provider to the resource they need if they could not provide the training and incorporate their feedback into the QM Plan. The first action step would be to review and update the QM Plan and work plan on a quarterly basis at the ISU QM team meeting. The next step would be to obtain input and feedback from the Leadership team on the QM Plan and workplan. DHH would explore an opportunity to present QM Plan including at the DHH all-staff meeting to get input and feedback.

G. Krull-Aquila reviewed goal 4 of the QM Plan. Goal 4 stated that DHH planned to increase capacity building among programs to support quality management activities. Their first objective for this goal was to create and offer innovative training for providers to enhance their quality management skills. The first action step was to develop online training modules for providers in CAREWare 6. DHH would continue discussions regarding CAREWare centralization on the State server with relevant stakeholders. They would then develop new trainings and provide technical assistance resources for subrecipients on the QI coaching model, Lean Six Sigma, and other relevant QI methodologies.

K. Carter asked how they knew the persons taking the training had comprehended and absorbed the information. G. Krull-Aquila said that the training modules were meant to be supplemental and were meant to act as a refresher. She said some people were visual learners and did not learn well from reading a manual, so this would help cement the information.

S. Anzuman said that CAREWare was their database and that not everyone in DHH could access it. She said that the database would only be helpful to a few people who were dealing with CAREware in the program department.

The next action step in goal 4 was to explore the feasibility of Lunch and Learn type training to subrecipients on various QM topics. G. Krull-Aquila continued to objective 2 of goal 4. The second objective focused on establishing and helping organize a peer-sharing network for programs where people could learn from each other's QI work. The action step for this objective was to compile and confirm a list of programs interested in participating in the network. The next step was distributing contact information and QIP topics to interested participants.

G. Krull-Aquila asked the committee to consider the three questions she had given them in the HIPC meeting. The three questions were:

1. Are there gaps in our plan?
2. What are some of the most important concerns of our consumers from a quality point of view?
3. Are there aspects of quality we should be looking at but aren't?

G. Grannan said in the previous HIPC meeting on March 9, 2023, he had asked a question about a non-criminalized person vs a criminalized person's ability to access care. He was told by the person presenting then that they would investigate the issue. G. Grannan said that even a non-criminalized person would be affected by the issues that a criminalized individual would be facing depending on other factors in their lives. G. Grannan said they should get input from the people facing these issues. S. Aznuman asked him if he was talking about HIV criminalization or general criminalization. G. Grannan clarified that he was speaking about both. He added that he was also speaking about people who were using drugs and those engaged in sex work. He said

the QM Plan lacked representation of this small but significant population. S. Anzuman thanked G. Granna for bringing this to their attention and said it was worth investigating. G. Grannan said they should be aware some people were unwilling to speak to programs and organizations if they feared there was a connection to law enforcement. S. Aznuman agreed that it would be difficult to capture this data.

Discussion Items:

-PA State Plan Concurrence-

M. Ross-Russell reminded the committee they had completed creating the Integrated Plan and that they had a presentation from DHH regarding the goals and objectives. She said that states were required to write a statewide statement of need. She said the statement of need was the same as an Integrated Plan. The EMAs were required to create an integrated prevention and care plan. M. Ross-Russell said the initial question was whether the city was going to do a coordinated plan with the state or were they going to do an individual plan. M. Ross-Russell said as far as she could remember, Philadelphia had always chosen to do its plan independently. M. Ross-Russell said if there was collaboration at the state level, it was through the health departments. Information to the state would be provided through their HIV planning groups (HPG) or community advisory boards.

M. Ross-Russell said that in this particular instance, they were notified in December 2022 that there was a requirement for a letter of concurrence from HIPC for the state plan. HIPC replied that they did not have any input within the state plan and therefore could not provide a letter of concurrence. She said that a letter of concurrence was not in the Integrated Plan nor the guidelines. She said she would have to provide some support documentation since HIPC had never had to complete a letter of concurrence for the State's Plan–nor had they reviewed or received a presentation on the plan.

G. Grannan asked if they were provided a time frame and if the committee allowed time to review the information before making the letter. M. Ross-Russell said there was no time frame yet. M. Ross-Russell recalled how CPC received a presentation from S. Moletteri comparing the PA State Plan and Philadelphia EMA's Integrated Plan. For the Philadelphia EMA's Integrated Plan, DHH met with HIPC and the other committees 4 times to offer information and collect feedback on the plan. Because of this, HIPC was able to provide concurrence since HIPC members could understand how the Philadelphia Health Department had reached their conclusions. However, in the case of the PA State Plan, M. Ross-Russell they have not received such information/presentations.

M. Ross-Russell said they were meeting next month to discuss the EHE update in April. In May, DHH would be presenting the epidemiological overview from the National HIV Behavioral Surveillance (NHBS). She said they would be preparing for allocations in June. HIPC would most likely have to finalize the allocations for the current year and then prepare for the upcoming year's allocations in July. In August, they would review the allocations process and discuss the

decisions regarding each region. M. Ross-Russell said September was the first month they did not have an activity scheduled.

M. Ross-Russell returned to the topic of the letter of concurrence. She said if the State of PA would like the letter, it would need to come from the whole Planning Body. G. Grannan asked if they had to do a meeting and then present it to the council. M. Ross-Russell said potentially yes. She added that the Health Resources and Services Administration (HRSA) needed documentation requiring HIPC to write the letter because the EMA encompassed two states. If it were a requirement for the State of PA, it would most likely be for the State of NJ as well. M. Ross-Russell said they may need a letter of concurrence in NJ.

When the State of PA had told M. Ross-Russell that they were required to write the letter of concurrence, they said HIPC was required due to the guidance. M. Ross-Russell said this would be the case only if the city of Philadelphia had done a joint plan with the state. The PA State Plan was not a joint plan.

M. Ross-Russell said the State of PA most likely believed that they must do a letter of concurrence if the counties included in the EMA represented more than 10% of the state's prevalence numbers. M. Ross-Russell said they had two choices: a letter of concurrence with reservations or a letter of non-concurrence. M. Ross-Russell said she had asked her project officer for documentation supporting the need for the letter of concurrence. There had not been a reply.

The CPC offered their support for M. Ross-Russell and said they had trusted her judgment. G. Grannan asked if they had wanted to ask for information about the letter of concurrence from NJ. P. Gorman said she knew K. Williams from the NJ HPG. P. Gorman said she could contact K. Williams to ask if the State of NJ asked for a letter of concurrence. She added that she had not heard from K. Williams about a letter of concurrence and concluded that it was requested only by the State of PA.

M. Ross-Russell said she had recalled that the State of NJ had approached Dr. K. Brady with a letter of concurrence. Dr. K. Brady said that the state did not have a joint plan with her and she could not provide a letter as a result. The State of NJ rescinded their request.

M. Ross-Russell said that while creating the Integrated Plan, she was on the Philadelphia Planning and NJ Planning committees. K. Carter asked if she was involved in the whole process of creating the NJ State Plan. M. Ross-Russell confirmed that she was. M. Ross-Russell said that the EMA and other organizations in NJ had worked with the State of NJ to create one complete plan. M. Ross-Russell said that if the State of NJ had asked during the process for information, they would have received it since it was a joint process. M. Ross-Russell said that information was also provided to the State of PA. She said they had provided the goals, objectives, and activities forwarded to the Planning Council. The States of NJ and PA provided their goals and objectives.

M. Ross-Russell summarized that they were waiting for the support documentation before they released a letter of concurrence. G. Grannan said they should say they were unwilling to alter their concurrence procedure. K. Carter asked if they needed to bring this issue to the full Planning Council. G. Grannan said they did not have to because they were not changing anything.

-Co-chair Nominations-

S. Moletteri said G. Grannan had been the sole chair for the CPC for some time. She said that due to time constraints, there was no time to discuss the nomination for a co-chair.

K. Carter asked P. Gorman and G. Keys if they wanted the position. S. Moletteri said there may be people who could not attend the meeting who would like the position. M. Ross-Russell asked the committee if they would like to table the discussion until the next meeting. S. Moletteri said she would accept nomination requests right now and via email so they could vote on the next meeting. Then she would contact the nominees to see if they were interested.

Other Business:

None.

Announcements:

K. Carter said he worked with the health department on March 27, 2023. They needed 20 people for a focus group to gather consumer feedback. He encouraged all interested to contact him so he could add them to the list. He said the time would be from 6 p.m. to 7:30 p.m. He said food would be provided and travel expenses would be compensated with the Septa one pass card.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion:** K. Carter motioned, and P. Gorman 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:

- March 2023 Meeting Agenda
- February 2023 Meeting Minutes
- PA Integrated Prevention Care Plan 2022-2026 (PDF)

Prevention Committee
Meeting Minutes of
Wednesday, April 26th, 2023
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Gus Grannan, Diamond Jackson, Erica Rand, Client Steib, Desiree Surplus, Adam Williams

Excused: Lorett Matus

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

Call to Order/Introductions: C. Steib asked everyone to introduce themselves and called the meeting to order at 2:33 p.m.

Approval of Agenda:

C. Steib referred to the April 2023 Prevention Committee agenda and asked for a motion to approve. **Motion:** K. Carter motioned; A. Williams seconded to approve the April Prevention Committee agenda via Zoom poll. **Motion passed:** 6 in favor, 1 abstaining. The April 2023 agenda were approved.

Approval of Minutes (*March 22nd, 2023*):

C. Steib referred to the March 2023 Prevention Committee minutes. **Motion:** K. Carter motioned; G. Grannan seconded to approve the March 2023 Prevention Committee meeting minutes and agenda via a Zoom poll. **Motion passed: 5** in favor 2 abstaining. The March 2023 Minutes were approved.

Report of Co-chairs

None.

Report of Staff

T. Dominique said she had sent the Prevention Committee an email requesting a one-on-one meeting to do a check-in.

Discussion Item:

-Integrated Plan-

T. Dominique said they would review the diagnosis and prevention goals of the Integrated Plan. She reviewed the actions taken in the diagnosis part of the plan, which was on page 34 of the Integrated Plan.

The actions taken under the diagnosis section of the Integrated Plan looked to provide accessible sexual health services, focusing on overall sexual wellness to decrease stigma around HIV testing. The plan proposed appointing clinical advisors to detail public health detailing to increase opt-out testing, repeating testing, and biosocial screening where opt-out testing isn't available. The plan also intended to implement HIV testing in select pharmacies and include expanded hours and more availability for testing in zip codes with higher incidence rates of HIV. To encourage testing, the Department of Health aimed to maintain HIV testing at no cost. Additionally, they hoped to continue HIV self-testing programs and launch an HIV testing media campaign to destigmatize HIV testing. The Integrated Plan would maintain the Philly Keep on Loving (PKOL) website, which would provide information on HIV testing.

T. Dominique reviewed the action steps of the prevention goal in the Integrated Plan. The plan included the establishment of a Center of Excellence in Philadelphia, providing 24/7 access to nonoccupational post-exposure prophylaxis (NPEP). DHH also launched a TelePrEP program on the PKOL website. The plan would appoint a clinical advisor to do public health detailing for PrEP provision. The plan launched PKOL and a TelePrEP media campaign to de-stigmatize PrEP. The Department of Public Health collaborated with key stakeholders to make PrEP and PEP more accessible and available.

G. Grannan asked who was the target demographic of these action steps. T. Dominique responded that the target under the diagnosis and prevention section of the Integrated Plan had targeted people who injected drugs, black men who had sex with men (MSM), women, and high-risk youth. G. Grannan agreed that these were target demographics, but he suggested they still needed to reach out to clinicians and health providers who may be skeptical of PrEP. G. Grannan emphasized that clinicians and other health providers should be taught the value of PrEP, both in their education and job training, without putting their professional futures at risk.He said many clinicians were not responsible for their attitudes towards PrEP because of the educational background in which they were trained. He said that many of the committee's activities had focused on patients' understanding of PrEP. He suggested raising awareness about PrEP among both the general population and healthcare providers.

A. Williams asked G. Grannan if the point he had discussed were previously covered in the Philadelphia Ending the HIV Epidemic (EHE) Plan under the workforce development pillar. T. Dominique clarified that the EHE Plan was different from the Integrated Plan, though the two plans had worked together in tandem. T. Dominique said that if the committee had found a deficiency or an issue, they could send a directive to the recipient from the HIV Integrated Planning Council (HIPC). The recipient may not be able to resolve the issue, but they would need to address the concerns put forward. T. Dominique mentioned if the Prevention Committee had felt clinicians did not receive education about PrEP, they could bring the issue to the recipient through HIPC. M. Ross-Russell explained that directives were part of the allocations process and acted as both requests and recommendations they could send to the Department of HIV Health.

K. Carter asked if it was necessary to educate both providers within and outside the Ryan White system about PrEP. M. Ross-Russell clarified that the concerns G. Grannan had about clinician knowledge of PrEP had affected all clinicians whether they were in the Ryan White System or not. T. Dominique said though they may advocate for more PrEP education in clinician training, clinicians and the medical school institution had the final decision on whether to elect coursework related to PrEP. K. Carter said clinicians did not have enough incentives to learn about PrEP. He said they did not know which practitioners had prescribed PrEP until they had advised patients to ask their primary providers about PrEP.

M. Ross-Russell asked the committee to describe the patient experience when they ask for PrEP. T. Dominique said the PrEP process would be dependent on the provider. M. Ross-Russell said that it was important that the process to receive PrEP was transparent and accessible. She said the access to the information could prompt potential persons exposed to HIV to request PrEP. G. Grannan said that some providers followed the best practices and some that did not. He said there needed a way for patients to report stigma against PrEP without punishing the clinicians for one response. G. Grannan said they should discuss with the health provider if PrEP stigma was found. He said that patients were entitled to expect engaging care such as the Mazzoni Center or their primary care provider.

C. Steib asked to return to the Prevent action steps slide. He said the action step regarding appointing a clinical advisor had been completed by the Department of HIV Health (DHH). He said DHH had hired a clinical advisor to present information about PrEP and HIV to health providers. C. Steib explained that the word “detailing” had originated in pharmaceutical companies where representatives would visit health providers to persuade them about the benefits of a new drug. He recommended that they invite the clinical advisor to speak to the HIPC or the Prevention Committee. He said they could gauge DHH’s progress toward educating providers about PrEP and and request a list of clinicians who were prescribing PrEP.

T. Dominique paused for questions before moving on to the objectives and key activities and strategies of the diagnosis section of the Integrated Plan. The first goal was to diagnose 95% of persons living with HIV by 2026. The first objective was to expand opt-out HIV screenings and diagnostic testing in at least 50 healthcare and other institutional settings. The key strategies and activities were to expand opt-out testing in DHH-funded emergency departments, increase efforts to educate medical providers about conducting opt-out HIV testing, educate clinical providers on bio-social HIV screening in clinical settings, and promote opt-out HIV testing for all DHH-funded providers.

The second objective was to maintain HIV testing services in non-clinical settings using rapid point-of-care testing or 4th generation laboratory testing. The key strategies and activities were to increase status-neutral testing in priority populations, support HIV self-testing through telehealth programs, and build capacity for non-clinical HIV testing.

The third objective was to implement routine opt-out testing at intake to substance use treatment facilities. The key strategies and activities were to implement routine opt-out testing at intake to

substance use treatment facilities, promote testing in primary care settings, implement testing in pharmacies in priority zip codes, and support capacity building in novel settings.
T. Dominique said the goals and timeline for the Integrated Plan differed from the EHE Plan. She said they had received an update from A. Thomas-Ferraioli in the April 13,th, 2023 HIPC meeting where they had received more information about the timeline and goals. For example, the Integrated Plan aimed to diagnose 95% of people living with HIV by 2026 instead of 2026 as mentioned in the EHE Plan. T. Dominique said that DHH had provided a way to view their goals to reach a diagnosis 95% of people with HIV on their dashboard.

The second goal was to eliminate disparities in non-clinical HIV testing. The first objective was to increase the number of partners to address syndemics to reduce new HIV diagnoses. The first key activity was to implement HIV/Viral Hepatitis Service integration. The second key activity was to collaborate with substance use facilities. The third key strategy was to work with the Pennsylvania and New Jersey Departments of Health to address interrelated factors exacerbating HIV.

The second objective was to enhance health equity efforts through policy and process improvements. DHH looked to implement and coordinate health equity efforts with the Pennsylvania and New Jersey Departments of Health. They also aimed to extend current health equity efforts to DHH-funded prevention providers.

The third objective was to evaluate HIV testing programs to address disparities in priority populations on an annual basis. The first key activity for this objective was to use public health data to identify disparities in non-clinical HIV diagnosis. The second activity was to provide feedback to funded providers. The third activity was to implement Continuous Quality Improvement (CQI) to address disparities.

Goal 2 of the integrated Plan listed the partners and potential funding sources.The partners involved with the Integrated Plan were the Philadelphia Office of HIV Planning (OHP), Philadelphia Department of Public Health Division of Disease Control (PDPH DDC), Ryan White (RW) funded clinical providers, health care facilities, community-based providers, Philadelphia County Prison Health Services, non-clinical testing sites, hospital emergency departments, sexual wellness clinics, and the Pennsylvania and New Jersey Departments of Health.

The potential funding sources included the CDC HIV Prevention and Surveillance Prevention Cooperative Agreement, the Pennsylvania Department of Health, the City of Philadelphia General Revenue, Medicaid, and other public and private funding sources. T. Dominique said the estimated funding allocation totaled $11,790,060.
T. Dominique said the expected outcome for the goal was to diagnose 95% of people with HIV and to link 95% of newly diagnosed individuals to HIV medical care within 96 hours of diagnosis. Data would be monitored from the Philadelphia EMR, Pennsylvania, and New Jersey Departments of Health and EvaluationWeb. The expected outcome of the HIV Care Continuum (HCC) and the Philadelphia EHE Initiative would be to increase the number of people who knew their HIV status to 95% and link these individuals to medical care within ours.

A. Williams said he had found that it was interesting that the PDPH DDC and the DHH were listed as partners but the PDPH Ambulatory Health Services (AHS) were not directly referenced. T. Dominique asked him why they should be included. A. Williams replied that the PDPH AHS was one of the PDPH organizations involved with HIV community engagement and direct services. He said PDPH AHS had multiple sites throughout the city and contributed significantly to implementing EHE activities. T. Dominique confirmed with A. Williams that he was requesting to include PDPH AHS as a partner in the future. C. Steib asked if PDPH AHS would be included as RW-funded clinical partners. A. Williams answered that not all PDPH AHS sites were funded in the same way. He said some were funded through DHH and others were funded through the state of PA. T. Dominique asked if they should be included in the category under facilities and community-based organizations or if they should make an exception for this organization. A. Williams said that they should be included because the DPPH AHS provided service to individuals who were often uninsured or were unable to receive services elsewhere. He believed that if they did not include PDPH AHS, they would be missing the organization that served a significant number of vulnerable populations.

T. Dominique said that PDPH DDC was included in the list because of their work with viral hepatitis and sexually transmitted diseases. She said she could not say definitely since she was not part of the meeting when the Integrated Plan was created. M. Ross-Russell said they had created this list to be comprehensive while attempting to be concise. A. Williams asked why they did not list all the PDPH organizations under PDPH to be concise and inclusive. A. Williams felt that the health centers were being left out. M. Ross-Russell said they did not intend to leave the health centers off the list. Rather, it was human error that lead to organizations missing from the list.

T. Dominique said they had finished reviewing the diagnosis section of the Integrated Plan. She asked if there were any recommendations or improvements they could forward to HIPC. A. William said they should strengthen avenues to PrEP through primary care physicians in addition to through DHH and PDPH DDC. He referenced a study from John Hopkins where researchers had interviewed cis black women about their barriers to PrEP. The researchers interviewed the women and learned that women felt they were stigmatized when they were prescribed PrEP by someone other than their primary care physician. A. Williams sent the research journal to the committee. The title of the research article was “Experiences of Black Women in the United States Along the PrEP Care Continuum: A Scoping Review.”

T. Dominique reviewed the Prevention goals. The first goal was to use biomedical interventions to reduce new HIV diagnoses by 75%. The first objective was to prescribe PrEP to 50% of people with a PrEP indication. The first key activity was to expand the current network of low-threshold sexual wellness clinics to provide HIV, STI, and hepatitis C virus (HCV) testing, PrEP, post-exposure prophylaxis (PEP), and linkage to HIV, STI, and HCV treatment in Philadelphia. The second objective was to expand PrEP access and provider capacity through low-threshold implementation models such as same-day PrEP, TelePrEP, nurse-extended PrEP, pharmacy-administered PrEP, and PrEP in drug treatment centers and behavioral health programs. The third objective was to pursue new PrEP partnerships with the Pennsylvania and New Jersey Departments of Health. The fourth objective was to expand financial support for PrEP-related routine laboratory work, through provider and home-collected specimens, and

adherence services. The fifth objective was to continue to provide ongoing technical assistance for the implementation of PrEP. The sixth objective was to expand PDPH DHH's capacity to evaluate PrEP uptake. The seventh objective was to increase knowledge of PrEP among the most impacted populations through communications and outreach. The eighth objective was to increase the number of providers trained to prescribe PrEP. The ninth objective was to develop collaborations with providers to expand PrEP screening to people who inject drugs. The tenth objective was to support research into expanding PrEP access and uptake among underserved populations. The eleventh objective was to collaborate with the Pennsylvania Department of Health Data-to-PrEP initiative. The twelfth objective was to increase the uptake of antiretroviral therapy (ART) as a method of prevention.

T. Dominique reviewed the second objective of the Prevention goals. The objective was to ensure access to nPEP. The first key activity was to establish a centralized mechanism to distribute PEP through a PEP center of excellence. The second key activity was to establish PEP partnerships with the Pennsylvania and New Jersey Departments of Health. The third key activity was to develop an initiative to address gaps in the provision of PEP including capacity, education, and resources.

C. Steib asked if the document could be amended or updated. He said they should amend the Integrated Plan to include educating and expanding PEP knowledge to emergency services around the city. He said many sexual assault cases were handled by emergency services. He said these cases had represented a missed opportunity. T. Dominique asked if this suggestion could be included in the third key strategy and activities of objective 2 under prevention goals.

K. Carter said that many sexual assault survivors may not be able to speak due to trauma. He said it would be difficult to evaluate potential patients. G. Grannan asked for a definition of capacity. G. Grannan asked the committee what was the meaning behind including capacity in the third key activity of the second objective. He asked if the definition had included how time-dependent PrEP was. He said PrEP was effective if it was administered within 72 hours. J. Haskins said including capacity was more related to educating the community about PrEP. T. Dominique believed capacity was related to staffing. She said when the PEP Center of Excellence was created, they did not have enough people to staff it even though they were a 24/7 hotline. She believed capacity was similar to that situation.

T. Dominique proceeded to the next portion of the presentation. She reviewed the third objective of prevention goals. The third objective under prevention goal 1 was to support perinatal HIV prevention services for pregnant individuals. The first key activity was to provide specialized case management for pregnant persons living with HIV. The second key activity was to develop PrEP navigation support for pregnant HIV-negative women at risk of HIV acquisition. The third key activity of this objective was to conduct case surveillance for women with diagnosed HIV infection and their infants. The fourth key activity was to conduct perinatal HIV exposure reporting.

T. Dominique then reviewed the second goal of Prevention. The second goal was to increase the number of access points for evidence-based harm reduction services. The first objective was to expand access to harm reduction supplies through novel approaches. The first key activity was to

implement harm reduction vending machines intervention at pilot sites. The second key activity was to ensure the availability of syringes at pharmacies by maintaining the Pennsylvania Department of Health's standing order. The third key objective was to provide organizational development and capacity building to expand local partnerships and establish new organizations providing syringe service provider (SSP) services and new locations of service based on need and HIV public health data. The fourth key activity was to expand the capacity for syringe service programs to distribute and collect syringes from Ryan White HIV/AIDS (RWHAP)-funded sites. The fifth objective was to pursue the expansion of distributing syringes and other harm-reduction supplies in Emergency Departments and urgent care sites. The sixth objective was to engage with community members and stakeholders in program development and planning of harm reduction services through novel approaches to ensure that it meets the needs of people who use drugs and avoids duplications of services.

The second objective of goal 2 of prevention was to expand access to syringe service programs. The key activities to support this objective were to enhance linkage to substance use disorder treatment in SSPs, implement quality improvement plans as needed, provide more equitable SSP service geographically in Philadelphia, and advocate for the implementation of SSPs in the counties in the jurisdictions outside of Philadelphia and New Jersey counties in the EMA.

T. Dominique reviewed Prevention goal 3. The third goal was to reduce disparities in HIV-related prevention services in priority populations. The first key objective was to monitor local disparities along the status-neutral HIV. The first key activity to achieve the objective was to continue reporting data by demographics and risk groups in PDPH DHH HIV Surveillance Report. The second key activity was to maintain a bi-annual update of the EHE dashboard, which included HIV care metrics by demographics and risk groups. The third key activity of this objective was to measure MSM/ Transgender people who have sex with men (TSM) perspectives on HIV testing and PrEP access to monitor disparities in access to testing/PrEP among these groups.

The second objective of Prevention goal 3 was to reduce HIV-related disparities in new diagnoses among priority populations. The first key activity was to expand new PrEP clinical-community partnerships to engage focus populations. The second key activity was to continue the City-wide distribution of free condoms, including in high schools, locations accessed by youth, and syringe service programs. The fourth key activity was to expand the promotion and distribution of community-specific sexual wellness and harm reduction information and supplies through innovative approaches.

The third objective of Prevention goal 3 was to increase and support health promotion activities for HIV prevention in the communities where HIV was most heavily concentrated. The first key activity was to continue the distribution of condoms in the jurisdiction. The second key activity was to support media campaigns that advance HIV prevention and health promotion behaviors. The third activity of this objective was to encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, people who inject drugs (PWID), and people experiencing homelessness.
T. Dominique listed the partners involved in the Prevention goals. The organizations listed were PDPH DDC, PDPH Division of Substance Use Prevention and Harm Reduction (SUPHR),

Pennsylvania and New Jersey Departments of Health, RW-funded clinical providers, community-based organizations (CBO), and established SSP programs. T. Dominique identified potential funding sources for the prevention goals. The funding sources were the CDC HIV Prevention and Surveillance Prevention Cooperative Agreement, the Pennsylvania Department of Health, the City of Philadelphia General Revenue, Medicaid, and other public and private funding sources. T. Dominique estimated the funding allocation would be $12,800,184.
The expected outcomes would be an increase in the number of people on PrEP, especially in priority populations who have an indication for PrEP. These priority populations were cis-gender women who inject drugs, transgender individuals, MSM, MSM (13-24 years old), and PWID. The plan aimed to increase the percentage of cis-gender women who injected drugs to 75% of the population to be on PrEP. For MSM and MSM (13-24 years old), the plan aimed to increase the percentage of people in the demographic to 50% on PrEP. Likewise, the plan looked to increase the percentage of MSM (13-17 years old) on PrEP to 25% of the demographic. T. Dominique said the monitoring data source would be the Philadelphia Department of Public Health data and EvaluationWeb. T. Dominique said the expected impact on the HIV Care Continuum (HCC) and the Philadelphia EHE Initiative was an increase to 50% of people with a PrEP indication who were prescribed PrEP and a decrease by 50% in the number of PWID who report sharing syringes.

T. Dominique strongly recommended visiting the HIVPhilly.org website and reading the Integrated Plan. She said pages on actions taken were on pages 34 and 35. The information on goals and objectives was on pages 47 to 54. She asked the committee to think about how the information fits into the EHE and the pillars.

-Texas Judge Mandate Regarding PrEP Access-

A. Williams introduced himself as the Prevention Coordinator for the Philadelphia Department of Public Health's AHS division in their clinical services program. A. William had volunteered to present an overview of the Braidwood V. Becerra. He prefaced that though he was presenting the information, he was not an attorney. He said he would answer questions to the best of his ability.

There were six individuals at the center of the case. He said the Braidwood had referred to a self-identified for-profit Christian-owned business by Dr. Steven F. Hotze. The name Becerra referred to Xaviar Bercerra, who was the U.S. Secretary of Health and Human Resources. The plaintiffs protested that the mandatory Affordable Care Act (ACA) coverage for their employees had thrust economic harm to their employees. Braidwood Management had argued that their employees were forced to pay for health services they did not want nor need and this had included services they religiously objected to.

A. Williams said the case was an attack on the ACA. He said the plaintiffs did not have particularly strong reservations against PrEP but they did have a strong opposition against the ACA. He said funding sources backing the case sought to have a judge who had previously ruled against the ACA. He said this case had qualified as a shadow docket. He described shadow dockets as lawsuits specifically chosen to lay the foundation for future political agendas in higher

courts. A. Williams said the general strategy was stoking hatred against sexual minorities to invalidate health services that had benefitted many.

A. Williams said the plaintiffs had not only aimed to remove PrEP access but also to nullify preventative care mandates by the United States Preventive Services Task Force (USPSTF) for the ACA. A. Williams quoted from a peer-reviewed analysis of the court case by Dorman, D. McCluluskey. The quote said "In siding with the plaintiffs, Judge O' Conner has jeopardized access to critical health care services potentially affecting over 150 million insured Americans." A. Williams said this had affected about 45% of the US population. The business owners' third position said the owners' religious freedoms were infringed. They had opposed services that had supported LQBTQ+ on the grounds of religious rights. They argued that PrEP encouraged homosexuality and promiscuity.

The plaintiffs aimed to nullify other services than PrEP. A. Williams showed the committee a list of services the plaintiffs had aimed to change. These included cancer, chronic conditions, health promotion, pregnancy, and sexual and reproductive health. A. Williams said the plaintiffs had successfully painted the case as an MSM-specific issue when impeding PrEP amounts to the structural racism that perpetuates inequalities in healthcare along racial and ethnic demographics beyond its immediate impact on MSM communities.

PrEP was a central point of the EHE Plan. A. Williams said they knew that PrEP was successful in reducing the number of new HIV infections per year. He showed the graph depicting new HIV transmission rates falling by 8% from 2015 to 2019.

A. Williams reviewed the epidemiology of HIV in the United States. He showed the committee a chart depicting the percentage of people with HIV in each demographic. He said the populations most affected would be minority populations such as the Black/African American and Hispanic/Latino populations. In 2019, 40.3% of people with HIV were Black/African American and 24.7% of people with HIV were Hispanic Latino. Even though each accounted for less than 20% of the United States population.

A. Williams reviewed the different plans created in response to the court decision. Plan A was to file an injunction. A. Williams said this was in motion. They were also awaiting to see if the USPSTF ruling would stand. At the time, the court decision would only affect the individuals in the case.
Plan B would be to appeal the ruling and bring it to the Supreme Court. A. Williams said this was risky since it risked doing further harm to the ACA. The Supreme Court had a conservative majority and would likely rule against the ACA.

Plan C was to bring public awareness to the impact of Braidwood v. Becerra. A. Williams said that current contracts have been locked in for the current insurance year and they would need to wait until next year to see the effects of the court decision. A. Williams said they would need to initiate a bi-partisan campaign to support legislation that would alter the effects of the court decision.

K. Carter said they should demonstrate the impact that the court decision would have with numbers that people grasp. For example, he said they could show people the number of cis-gender people who would lose access to PrEP. He said they could also show the amount of money PrEP could save the state if fewer people were seeking HIV treatment because they used PrEP.

M. Ross-Russell said she had contacted Dr. K. Brady in anticipation of the presentation to ask her what government organizations were doing in response to the court case decision. She said the city of Philadelphia had assurances from the state Medicaid that they would honor the no-cost sharing clause for HIV prevention including PrEP. M. Ross-Russell said they were currently reaching out to insurers across the state for assurances. She promised to share information regarding the case to the committee.

T. Dominique reminded the committee that the meetings were informational and they encouraged the committee members to act on what they felt was right. She said as HIPC members, they were limited in some ways and she thanked M. Ross-Russell for providing the information on the state of PA and NJ's stance on the court decision. T. Dominique encouraged the committee members to vote in the Philadelphia elections on May 16th.

K. Carter asked if they could reach out to other organizations and to other EMA's to create a united response to the court decision. He reasoned that they should stand together because the result of Braidwood v. Becerra had affected the whole country. T. Dominique replied that they could not do that as HIPC members, However, if K. Carter had chosen to participate in another organization that advocates for that specific cause, the HIPC would not stand in his way. A. Williams agreed with T. Dominique and said it was important to vote in the election. He said the HIPC could not influence how the public votes but they could advocate for more people to vote. T. Dominique said it was important that people would vote for people who shared their values because the elected officials could be in office for a decade.

-Prevention Committee Survey-

T. Dominique said they had reviewed the Prevention Committee Survey together as a committee in the last meeting, but she did not allocate enough time for discussion. She asked the committee members to read the responses from the survey again and then request topics that they would like to discuss or have a presentation on in the next meeting. C. Steib asked if they could have more housing information. T. Dominique said there was a housing presentation at the January HIPC meeting. She asked what kind of housing discussion he had wanted. C. Steib said he was not present at that meeting. He said he would revisit the minutes of that meeting and hoped that would answer his questions.

M. Ross-Russell said C. Steib and T. Dominique were both at the EHE meeting last week. She said housing was a prevention issue as well in the meeting. T. Dominique said she asked those questions because she wanted to know how C. Steib wanted the housing discussion to be framed. C. Steib said he did not know yet what the discussion around housing would look like. He said he would review the previous presentation and revisit this topic.

Any Other Business:

None.

Announcements:

C. Steib said there was State HPG town hall in the King of Prussia area at the DoubleTree Hotel concentrating on the collar counties. They were inviting people from Philadelphia on May 17th at 3 p.m. C. Steib said he had information he could send to the committee about the event through email.

M. Ross-Russell asked if the event was virtual for those who could not attend in person. He sent a link to the event to the committee to register for the event.
G. Grannan asked if C. Steib would send transit directions with the informational email. C. Steib said he would send the directions after reaching out to the staff.

Adjournment:

C. Steib called for a motion to adjourn. **Motion:** G. Grannan motioned, and E. Rand seconded to adjourn the Prevention Committee meeting. **Motion passed:** Meeting adjourned at 4:15 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- April 2023 Meeting Agenda
- March 2023 Minutes

What Makes a Directive to the Recipient (DHH)?

CPC and Prevention Committee

Wednesday, May 24, 2023

Directives to DHH (the recipient) can be about any of the following:

- **Specific subpopulations**
- **Specific geographic areas**
- **How services should be provided** (service provision)
- **Types of organizations** (e.g. agencies that receive funding for and link both care and prevention services, CBO that service a particular subpopulation, nonprofit agencies, etc… **NEVER naming specific agencies**)

Comprehensive Planning Committee
Topics from September 2022 - May 2023
Wednesday, May 24, 2023

Non-Medical Case Management (NMCM):

Presentation from Cooper Hospital Refresher:

- The Health Coach would ensure that clients could get connected to Support Services such as food assistance, transportation, housing, emergency financial services (for housing, utilities, and urgent medication), community services, and dental services
- NMCMs focused on intake/acuity assessment, linkage to needed services, linkage to insurance within 30-60 days, and eventual linkage to MCM
- NMCM used for those who are initially entering or reentering care/those who can manage their own care and health well
    - For those initially entering or reentering care, NMCMs would perform a "warm hand-off" to MCMs
- No educational requirements for NMCMs

CPC Conversation Included:

- A suggestion to investigate the benefit of funding NMCM under Part A

Substance Use Services in NJ Counties:

Presentation from OHP Staff Refresher:

- Data from SAMSHA funding for FY2021 and special initiatives for different populations
- Most facilities were outpatient within NJ Counties
- Only a handful of programs offering information/services related to HIV:
    - **27.2%** of programs offered **HIV testing**
    - **63.2%** of programs offered **HIV education, counseling, or support**
    - **7%** of programs offered **HIV medications**
    - **30.8%** of programs offered **a program for clients with HIV or AIDS**

CPC Conversation Included:

- Information from the NJ Counties about substance use services, especially more information about the syringe access programs/harm reduction centers

HB103:

Presentation from OHP Staff Refresher:

- HB103 was signed into law and outlined a new penalty for spitting on all peace officers, extending the law that referred to only corrections officers. The penalty was a third-degree felony for spitting on an officer as an assault with up to 7 years in prison and a $15,000 fine. A person who knew they had a communicable disease would face a second-degree penalty with jail time of up to 10 years with a $25,000 fine.

CPC Conversation Included:

- Raising awareness which included a presentation to HIPC (this did happen)

NJ Transportation:

Presentation from NJ Division of HIV, STD, and TB Services Presentation Refresher:

- NJ presented on RWB (Ryan White Part B) and RWS (Ryan White Supplemental) for transportation services in NJ
    - Presentation did not include RW Part A types of reimbursement—not part of the presenter's division
    - RWB was intended for medical emergencies and medical services; state funding less restrictive
        - Reimbursements included public transportation, rideshares, personal drivers, taxis, gas cards, parking
- It was expected that agencies would spend down their transportation funding
- State-funded transportation sought to provide services from a status-neutral lens
- South Jersey seen as a transportation desert with lower demand for transportation
    - More sprawl; little to no public transportation; uber/rideshare drivers not incentivized to work in these areas

Concerns as Mentioned by the Positive Committee

1. **What are your prevention concerns in your community?** *Concerns could be about substance use, housing, food insecurity, sex work, etc.*

- White supremacy in larger organizations & a need to support smaller organizations that work with underserved populations (specifically Black & Latinx populations)
    - Ensuring that care for Black & Latinx populations is competent

- Spanish speaking workers (Language Line versus hiring from within the community)

- Lack of advocacy programs & mentorships

- Lack of affordable housing in locations with dependable transportation

- Addressing security concerns → people may not feel safe going into spaces, therefore not getting the care they need

2. What are your HIV prevention/service prevention concerns?

- *Lack of mobile HIV prevention care (for testing and PrEP)*
    - *Offering injectable PrEP immediately & incentive for coming back*

Philadelphia EMA Planning Council FY 2022 Priority Setting Tool

Possible Score (Scale varies by factor): 8, 5, 3, or 1

Service Category			Medical Monitoring Project (MMP)	Consumer Survey	Client Services Unit (CSU)	Community Voices						Service Category Total Score	Service Category Total Percentage
	Rank 2019	**Rank 2022**	20%	20%	20%	*Members Voting*	8	5	1	score before %	40%	Calculations	
Transportation	7	**1**	5	5	8	4	3	1	0	7.25	2.9	**6.50**	**81.25%**
Emergency Financial Assistance	6	**2**	5	8	3	6	6	0	0	8.00	3.2	**6.40**	**80.00%**
Housing Assistance	1	**3**	5	5	8	4	2	2	0	6.50	2.6	**6.20**	**77.50%**
Medical Case Management	2	**3**	5	3	8	6	5	1	0	7.50	3	**6.20**	**77.50%**
Dental Care	3	**3**	8	5	3	6	5	1	0	7.50	3	**6.20**	**77.50%**
Mental Health Therapy/Counseling	5	**4**	5	5	5	5	4	1	0	7.40	2.96	**5.96**	**74.50%**
Legal Services	19	**5**	5	5	3	4	3	1	0	7.25	2.9	**5.50**	**68.75%**
Ambulatory Care	4	**6**	3	3	5	5	5	0	0	8.00	3.2	**5.40**	**67.50%**
Substance Abuse Treatment (Residential)	12	**6**	3	5	3	7	7	0	0	8.00	3.2	**5.40**	**67.50%**
Food Bank/Home-Delivered Meals	11	**7**	3	5	5	4	2	2	0	6.50	2.6	**5.20**	**65.00%**
AIDS Drug Assistance Program (ADAP)	9	**8**	3	3	5	4	3	1	0	7.25	2.9	**5.10**	**63.75%**
Care Outreach	18	**8**	3	3	5	4	3	1	0	7.25	2.9	**5.10**	**63.75%**
Substance Use Treatment (outpatient)	8	**9**	3	5	3	5	3	2	0	6.80	2.72	**4.92**	**61.50%**
Psychosocial Support Services	10	**10**	3	5	3	4	2	2	0	6.50	2.6	**4.80**	**60.00%**
Health Insurance Premium & Cost Sharing Assistance	14	**11**	5	5	3	7	2	3	2	4.71	1.88	**4.48**	**56.00%**
Translation & Interpretation	16	**12**	1	5	3	7	4	2	1	6.14	2.46	**4.26**	**53.25%**
Health Education Risk Reduction	24	**13**	1	1	3	4	3	1	0	7.25	2.9	**3.90**	**48.75%**
Local Pharmaceutical Assistance	13	**14**	3	3	5	5	1	1	3	3.20	1.28	**3.48**	**43.50%**
Nutritional Services	21	**15**	1	5	1	6	1	4	1	4.83	1.93	**3.33**	**41.63%**
Early Intervention Services	23	**16**	1	1	1	5	3	2	0	6.80	2.72	**3.32**	**41.50%**
Day or Respite Care	28	**17**	1	5	1	4	1	2	1	4.75	1.9	**3.30**	**41.25%**
Child Care Services	22	**18**	1	5	1	7	2	3	2	4.71	1.89	**3.29**	**41.13%**
Information & Referral	20	**19**	1	1	1	7	4	2	1	6.14	2.46	**3.06**	**38.25%**
Case Management (non-medical)	15	**20**	3	1	5	6	0	3	3	3.00	1.2	**3.00**	**37.50%**
Rehabilitation Care	27	**21**	1	5	1	7	1	1	5	2.57	1.03	**2.43**	**30.38%**
Home Health Care	17	**22**	1	5	3	6	0	0	6	1.00	0.4	**2.20**	**27.50%**
Home & Community-based Health Services	25	**23**	1	5	1	6	0	1	5	1.67	0.67	**2.07**	**25.88%**
Hospice Services	26	**24**	1	5	1	5	0	0	5	1.00	0.4	**1.80**	**22.50%**

: greater than 3 change in rank