MEETING AGENDA

VIRTUAL:
Thursday, November 9th, 2023
2:00 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes (October 12th, 2023)
- Report of Co-Chairs
- Report of Staff
- Presentation
  - Integrated Plan: Treat & Response
  - Directives Response
- Committee Reports:
  - Executive Committee
  - Finance Committee – Alan Edelstein & Adam Williams
  - Nominations Committee – Michael Cappuccilli & Juan Baez
  - Positive Committee – Keith Carter
  - Comprehensive Planning Committee – Gus Grannan & Debra Dalessandro
  - Prevention Committee – Desiree Surplus & Clint Steib
- Other Business
- Announcements
- Adjournment

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org
The next HIV Integrated Planning Council meeting is
VIRTUAL: December 14th, 2023 from 2:00 p.m. to 4:30 p.m.
Please contact the office at least 5 days in advance if you require special assistance.

Philadelphia: HIV Integrated Planning Council
Meeting Minutes of
Thursday, October 12, 2023
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Alan Edelstein, Lupe Diaz (Co-Chair), Adam Williams, Michael Cappuccilli, AJ Scruggs, Clint Steib, Debra D'Alessandro, Desiree Surplus, DJ Jack, Gerry Keys, Greg Langan, Gus Grannan, Shane Nieves, Sharee Heaven (Co-Chair), Keith Carter, Lorett Matus, Pamela Gorman

Guests: Ameenah McCann-Woods (DHH), Blake Rowley, Javontae Williams (DHH), Jerome Pipes, Julia Sughrue, Mystkue Woods

Excused: Erica Rand, Jose Demarco, Evan Thornburg (Co-Chair), Jeffrey Haskins

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

Call to Order: L. Diaz called the meeting to order at 2:08 p.m.

Introductions: L. Diaz asked everyone to introduce themselves.

Approval of Agenda: L. Diaz referred to the October 2023 HIV Integrated Planning Council agenda and asked for a motion to approve. **Motion:** K. Carter motioned; L. Matus seconded to approve the October 2023 HIV Integrated Planning Council agenda via a Zoom poll. **Motion passed:** 12 in favor, 3 abstained. The October 2023 HIV Integrated Planning Council agenda was approved.

Approval of Minutes (*September 14th, 2023*): L. Diaz referred to the September 2023 HIV Integrated Planning Council meeting minutes and asked for a motion to approve. **Motion:** G. Grannan motioned; K. Carter seconded to approve the September 2023 HIV Integrated Planning Council minutes via a Zoom poll. **Motion passed:** 14 in favor, 2 abstained. The September 2023 HIV Integrated Planning Council meeting minutes were approved.

Report of Co-Chairs:
C. Steib gave his report on the evaluation subcommittee at the September Pennsylvania State HIV Planning Group (HPG) meeting. He said attendance was sparse due possibly to the event location. He said they received a report from the Special Pharmaceutical Benefits Program (SPBP) staff as a follow-up report to their previous report in January. They had given more information on how they hoped to enact goal 3 of the Integrated Plan which was to treat people with HIV rapidly and effectively. They hoped to achieve greater viral suppression with their Medication Adherence Program.

Report of Staff:
M. Ross-Russell stated that they would be reviewing the Integrated Plan in the upcoming HIPC meetings. They planned to review Pillars 1 and 3 at the current meeting and Pillars 2 and 4 in the November HIPC meeting. They also intended to review the processes for service standards. These meetings would be a collaborative effort between HIPC and the Division of HIV Health (DHH).

S. Moletteri reported that she had attended the Pennsylvania HPG meeting and had participated in a presentation on the National Aging with HIV Survey. This survey had been previously reviewed in the combined Comprehensive Planning Committee and Prevention Committee meeting in September. She mentioned that the state was organizing sessions on stigma, with meetings involving clients and providers discussing how stigma affects different groups. She also announced that the Positive Committee would meet in person next Monday at 12:00 p.m. There would be take-home lunches. She encouraged HIPC members to register for the meeting by sending her an email.

Presentation
-Integrated Plan: Diagnose and Prevent-
J. Williams greeted the HIPC members and said he would be presenting on pillars 1 and 3. He thanked the HIPC members and the Office of HIV Planning (OHP) for sending the Letter of Concurrence in December 2022. J. Williams stated that every 5 years Philadelphia and the other eligible metropolitan areas participate in the Integrated Planning process. The current Integrated Plan would cover 2022-2026. He noted that some of the CDC prevention activities would only apply to Philadelphia. He mentioned that Delaware and Montgomery Counties both have their own Health Departments working on HIV prevention, and the Philadelphia Department of Public Health (PDPH) looked to work closely with these two organizations.

The presentation agenda stated that DHH would be giving an update on their progress towards achieving the goals of the Diagnosis and Prevent Pillar of the HIV Integrated Plan. J. Williams lauded the progress they had been able to make since the plan was published in December 2022. He attributed the success to building upon the plans laid by the End the HIV Epidemic and existing plans in the community.

The Diagnose Pillar had two goals. The first goal was to diagnose 95% of persons living with HIV by 2026. The second goal was to eliminate disparities in non-clinical HIV testing. J. Williams then reviewed the objectives of each pillar and the activities and strategies used to achieve them. J. Williams said the objectives that were highlighted in blue were objectives he was going to provide further detail on.

Under goal 1, the first objective was to promote routine opt-out HIV screenings and diagnostic testing in at least 50 healthcare and other institutional settings. The first key strategy was to expand opt-out testing of PDPH DHH-funded emergency departments. The next objective was to continue opt-out testing in the Philadelphia Department of Prisons. The third strategy was to increase efforts to educate medical providers about conducting opt-out HIV testing. The fourth strategy was to educate clinical providers on biosocial HIV screening in clinical settings where

opt-out testing was not achievable. The fifth strategy was to promote opt-out HIV for all PDPH DHH providers. Key strategies 1, 3, and 4 were highlighted in blue.

J. Williams provided an update on the progress on the objective to promote routine opt-out HIV screenings and diagnostic testing in at least 50 healthcare and other institutional settings. DHH has developed new training resources such as the provider portal on the PhillyKeepOnLoving website to educate providers on opt-out HIV testing. The portal would provide digital biomedical toolkits and handouts that providers can download to augment their knowledge. DHH provided protocol and workflow templates that can be adapted by providers. J. Williams said DHH collaborated with partner agencies to deliver training and provide continuous education credit for providers. They presented on opt-out HIV testing at quarterly provider meetings. DHH used PS18-1802 funds for routine screening at the Department of Prisons medical intake. 12, 523 HIV tests were conducted between 7/1/22 and 6/30/23.

Under goal 1, 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 first key strategy was to increase status-neutral testing in priority populations. The second strategy was to support HIV self-testing through a telehealth program. The third strategy was to build capacity for non-clinical HIV testing. All strategies under objective 2 were highlighted in blue.

J. Williams provided more detail for goal 1, objective 2, and activity 2.1. In 2020, DHH sought to increase HIV testing in priority populations by realigning services to improve the cost-effectiveness of testing programs. This process involved community engagement, low threshold access, and other HIV prevention services. The priority populations that they had looked to increase testing were men who had sex with men (MSM), persons who inject drugs, cis-gender heterosexual, Black/African American/Latina women, and transgender persons who have sex with men.

T. Dominique notified J. Williams that G. Grannan had wanted to ask a question. J. Williams asked T. Dominique if she would allow questions to be asked at the end of the presentation due to time constraints. He said he had 50 more slides in the presentation to cover and he knew the agenda was full. He said some questions may be answered as he goes through the presentation. He acknowledged that he was a guest at the HIPC meeting and was willing to be flexible if the HIPC members were willing to invite him to the next meeting to cover the content that was not covered in the meeting.

J. Williams continued with his presentation and spoke about goal 1, objective 2, and activity 2.2. The strategy was to provide free HIV self-test kits to Philadelphia residents through Philly Keep On Loving (PKOL) and partner agencies. J. Williams said the program began in October 2019 with mail distribution of self-test kits through PKOL. Fourteen community-based organizations (CBOs) were to distribute the self-tests to the community. J. Williams said Pennsylvania residents were able to access the self-tests through their state website and PKOL. To receive a test, the person must be 17 years or older, reside in Philadelphia County, and cannot have received a test kit within the last 3 months. J. Williams asked the HIPC members to look at the bar graph to the right of the slide depicting the number of HIV self-test requests from January 2021 to June 2023. He mentioned that during this time period, PKOL and its partners had

distributed 4,923 total test kits. He said the test kit requests had mainly been placed by Black/African Americans and MSM under the age of 30. He said he had great hopes that the program was reaching its target population.

DHH collaborated with the STD Control Program to provide more sexual wellness products and house calls on PKOL. The products included condoms, lubricants, and STI self-collection kits. PKOL could send a specialist to perform an STI test at someone's home. DHH had hired a fulfillment specialist to centralize mail-order fulfillment. J. Williams said there was a new advertising campaign that launched in June 2023. He showed the HIPC members an example of one of the advertisements. On the left side of the slideshow presentation, there was a picture with a silhouette of a person and a caption with the words "Discreet? You got it. Get your Free at-home HIV and STI test kit." J. Williams said they had used this advertisement on a number of dating apps. J. Williams stated that DHH was partnering with The Penn Center for AIDS Research (Penn CFAR) to understand who was benefiting from the program and what other populations could benefit from the program.

J. Williams continued to Objective 3 under goal 1. The objective was to implement novel HIV testing initiatives. Objective 3.1 was to implement routine testing at intake to substance use treatment facilities. Objective 3.2 was to promote testing in primary care settings. Objective 3.3 was to implement testing in pharmacies in priority ZIP Codes. Objective 3.4 was to support capacity building in novel settings.

In 2023, DHH launched a pharmacy testing program. The goal of the program was to expand access to status-neutral HIV testing outside of traditional clinical and CBO settings through community-based retail pharmacies. PDHP identified 13 priority ZIP codes for this request for proposal (RFP) based on local analysis of recent data on HIV testing, newly diagnosed HIV, and HIV testing resources by ZIP code. J. Williams updated the HIPC members on the progress on this program by stating that all the sites that they had awarded funding were operating as of August 2023. J. Williams reported that due to rioting, Sunray Specialty Pharmacy, a pharmacy on 52nd Street, was damaged. Due to the situation, Sunray Specialty Pharmacy had to pause HIV testing. He said DHH was currently assessing the situation and assisting Sunray with rebuilding.

J. Williams listed and then explained the pharmacy HIV testing core components. He said they had aimed to have low-barrier access. This meant walk-in availability, expanded hours, and no insurance requirements. The priority populations would be gay, bisexual, and other MSM, transgender women, Black and African American Individuals, Latinx individuals, and people who inject drugs. The core activities were to conduct confidential HIV testing in priority ZIP Codes and provide client education on U=U (undetectable=untransmittable), condom use, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and the PDPH home testing program. The program would also refer clients interested in PrEP and PEP to those respective services. For those who were testing HIV positive, the program would expedite linkage to HIV care, defined as a medical visit (or telemedicine visit).

The next slide in the presentation looked at a chart detailing the comparison of the cost of traditional rapid HIV testing programs and the Integrated Sexual Health Services Model in 2019. In 2019, PDPH invested $2,073,520 in traditional community-based HIV testing in 12 locations.

J. Williams explained that this method of testing involved the client walking into a location and getting tested. During this year, PDPH found that there were a total of 24 new HIV diagnoses in these locations. The cost to diagnose and link one person to effective HIV treatment was $86,397. At the same time, there were 3 locations completing integrated sexual health services. These services included STI testing, pregnancy testing, and treatment for gonorrhea and chlamydia. These three locations identified 69 new HIV diagnoses. The cost to diagnose and link one person to effective HIV treatment was $14,602. J. Williams concluded that the second method was more effective at finding new diagnoses of HIV. He said the traditional community-based HIV testing model required that the client take ownership of their health and know to get tested. J. Williams said this option could also require providers to be more active in finding HIV diagnoses in their communities. He said this had become more difficult as communities have moved to more online spaces and there were fewer places that people congregate such as gay bars.

J. Williams then introduced a third option to increase HIV diagnoses. The strategy was to improve the cost-effectiveness of the testing programs. DHH would reduce the number of agencies funded solely for HIV testing and funnel the resources into comprehensive sexual wellness sites. J. Williams said these sites would provide low-barrier, culturally informed sexual wellness services for communities. The sites would allow for walk-in availability, extended evening and weekend hours, telehealth, and no insurance requirement. J. Williams said there were 4 sites that were currently operational and focusing on low-threshold sexual health services (L-SHS). Each location focused on one priority population such as MSM and women of trans experience, Black and African American Philadelphians, Southwest Philadelphia residents, and Latinx Philadelphians. J. Williams said the programs were finding success because they had taken the time to hire people from the community population they were aiming to help.

The presentation continued to goal 2 of the Diagnosis Pillar. Goal 2, objective 1 was to increase the number of partners to address syndemics to reduce new HIV diagnoses. J. Williams defined syndemics as the presence of different comorbidities in a person. He said there were factors that contributed to HIV transmission and people living with HIV likely have to tolerate other health or environmental conditions. J. Williams read the key strategies and activities for goal 2, objective 1. Key activity and strategy 1.1 was to implement HIV/Viral Hepatitis Service Integration. Activity 1.2 was to collaborate with substance use facilities. Activity 1.3 was to work with the Pennsylvania and New Jersey Departments of Health to address interrelated factors exacerbating HIV.

After reading the key activities, J. Williams presented a progress report on achieving the goal. DHH worked with the Viral Hepatitis Department at PDPH to integrate services and fund L-SHS. DHH collaborated with Substance Use Disorder (SUD) Treatment Facilities and Community Behavioral Health (CBH). DHH then introduced and required SUD Treatment sites to have on-site testing or referral for HIV, Hepatitis C, and Hepatitis B. J. Williams said progress towards this had been improved since 2019 but there was room for improvement. DHH had also provided resources and educational materials encouraging self-testing for distribution to SUD Treatment sites. DHH encouraged providers to co-prescribe PrEP with Medication-Assisted Treatment (MAT). J. Williams then showed HIPC members a chart depicting the number and rate of CBH members who received an HIV test within 3 months after an ambulatory SUD treatment

for Opioid Use Disorder (OUD). He said the number of CBH members receiving an HIV test was improving slowly with time but there was room for improvement.

J. Williams moved to goal 2 objective 2. The objective was to enhance health equity efforts through policy and process improvements. Key activity 2.1 was to implement and coordinate health equity efforts with the Pennsylvania and New Jersey Departments of Health. Key activity 2.2 was to extend current health equity efforts to PDPH DHH-funded prevention providers. He said DHH had been cooperating with a number of providers to launch a health equity assessment and they were in the process of translating that to their prevention providers. He said they looked to find ways in which providers could better serve their clients equitably. DHH also wanted to understand the providers' staff environment because DHH valued staff equity. J. Williams said DHH met monthly with the Pennsylvania Department of Health to better coordinate efforts. DHH was also implementing health equity assessments for all PDPH DHH-funded providers. He reported that all L-SHS sites have completed health equity assessments and were in varying stages of implementing benchmark plans in response to assessments. DHH planned to expand the health equity assessments to all prevention providers in 12 months.

J. Williams then reviewed goal 2, objective 3. The objective was to evaluate HIV testing programs to address disparities in priority populations on an annual basis. Key activity 3.1 was to use public health data to identify disparities in non-clinical HIV diagnoses. Key activity 3.2 was to provide feedback to funded providers. Key activity 3.3 was to implement continuous quality improvement (CQI) processes to address disparities. J. Williams provided more information on the progress being made for this objective. He said data was being used to focus resources on high-impact interventions like Pharmacy Testing. He said quarterly feedback reports were also given to providers routinely. DHH conducts monitoring across teams. For example, DHH conducts site visits by program analysts and conducts annual DHH-team visits to L-SHS. J. Williams said the DHH Information Services Unit (ISU) was conducting CQI and working on improvement plans with various providers.

After reviewing the goals and objectives of the Diagnose Pillar. J. Williams said they would be reviewing the Prevention Pillar. He gave the HIPC an overview of the Prevention Integrated Plan goals. The first goal was to use biomedical interventions to reduce new HIV diagnoses by 75%. J. Williams defined medical interventions as PrEP, PEP, and anything similar that would prevent HIV transmission. The second goal was to increase the number of access points for evidence-based harm reduction services. The third goal was to reduce disparities in HIV-related prevention services in priority populations.

The first Prevention Pillar objective was to have 50% of people with a PrEP indication be prescribed PrEP. The objective had 12 key strategies and activities. Activity 1.1 was to expand the current network of low-threshold sexual wellness clinics to provide HIV, STI, and HCV testing, PrEP, PEP, and linkage to HIV, STI, and HCV treatment in Philadelphia. Key activity 1.2 was to expand PrEP partnerships with the Pennsylvania and New Jersey Departments of Health. Activity 1.4 was to expand financial support for PrEP-related routine laboratory work through provider and home collected specimens, and adherence services. Key strategy 1.5 was to continue to provide ongoing technical assistance for the implementation of PrEP. Key Activity 1.6 was to expand PDPH DHH's capacity to evaluate PrEP uptake. Activity 1.7 sought to

increase knowledge of PrEP among the most impacted populations through communications and outreach. Activity 1.8 would increase the number of providers trained to prescribe PrEP. Activity 1.9 was to develop collaborations with providers to expand PrEP screening to people who inject drugs. Activity 1.10 supported research into expanding PrEP access and uptake among underserved populations. Activity 1.11 collaborated with the Pennsylvania Department of Health Data-to-PrEP Initiative. Activity 1.12 increased uptake of Antiretroviral therapy (ART) as a method of prevention (U=U).

J. Williams provided DHH's progress on accomplishing this objective. DHH had hired a new PrEP/PEP Coordinator for enhanced activities. DHH developed new training resources such as a Provider portal on PKOL, a digital biomedical toolkit, etc. to educate providers on opt-out HIV testing. DHH had ongoing collaborations with PENN CFAR to evaluate interventions. The current projects included Pharmacy Testing, PrEP Uptake, Self-testing, and TelePrEP. iART policies were placed at all Philadelphia-based treatment programs. J. Williams said they were bringing these policies to all Philadelphia-based HIV testing and L-SHS sites. He said clients were linked to ART within 96 hours of their first positive HIV test. He said DHH had a PreP Provider workgroup that collaborates with the Hepatitis Technical Assistance Center to bring providers together to discuss challenges and barriers to treatment and care.

The next section of the presentation centered on PKOL. J. Williams shared new details about PKOL. He said PKOL had started as a website and evolved into a prevention ecosystem with a myriad of services. J. Williams said TelePrEP, Self-Test Self Collection, condoms and lube distribution, health information, helpline chat, podcasts, testing and resources finder, and 24/7 PEP access were some of the things users could access on the website.

J. Williams said he noticed there were at least 10 messages in the chatroom. He said he would respond to the questions soon. J. Williams would then review DHH's TelePrEP program. The RFP for TelePrEP was published in December 2021. The award was made to Albert Einstein Medical Center (AEMC) in February 2022. He said the program offered a brick-and-mortar site in-person services such as injectable PrEP and STI treatment. He said the program offered medical and navigation staff with an awareness of and capacity to provide comprehensive services that address barriers to PrEP uptake. He said there were navigation and adherence support services available. He then said they were forming partnerships with Health Center 1, Community Mobilization Agencies, and local HIV testing sites that don't currently provide PrEP Services. J. Williams said that clients went to a COLOURS or Prevention Meets Fashion meeting and had access to a TelePrEP. He warned the members that TelePrEP may not be readily available at the places he listed since the partnerships were still in development.

J. Williams then described the process of enrolling in PrEP. The person would be searching the internet for PrEP or click on an advertisement. They would find themselves on the PKOL website. From there, they can self-schedule an appointment. J. Williams said if the person had more questions they could start asking questions by texting "PrEP" to 1-215-709-7826. Someone would then reply back to them if the text was sent 7 am - 3 am. If it is outside those hours, the person would receive an automated message. Once the appointment has been confirmed with a navigator, they would complete their lab testing through self-collection or at a local lab of their choice. J. Williams said that to perform a self-collection, the person would need to prick their

finger and send a dry blood spot on a piece of paper. They would send it to a lab where tests can be performed. Once test results were received, the client then completed their first Telehealth visit with a provider and discussed their PrEP options. J. Williams said PrEP options included injectable and oral options. Then, depending on the client's choice of PrEP modality, the medication can be delivered to a pharmacy of their choice, delivered to their residence for free or the client can come to AEMC for an injectable. Then follow-up was conducted by the navigator every 3 months with routine labs and provider appointments included.

J. Williams then shared some digital advertisements with the HIPC members. The digital advertisements were used to promote TelePrEP. The ads were promoted on Google Search & Display and Dating Apps. J. Williams was proud to announce that if someone searched sexual wellness PKOL appeared in 1 out of 5 searches. J. Williams provided an update on TelePrEP uptake. The program started in October 2022 and J. Williams was providing an update for the progress up to August 2023. 145 people have been enrolled during this period. 79 people have started PrEP. J. Williams said he was excited they were close to 200 people enrolled. He said the bottleneck between the number of people enrolled and those who started PrEP was the time it took to return their test kits and set up their appointments. DHH considers people as initiating PrEP when the navigator has confirmed that the person has received the medication and was taking it. He said DHH was currently working with the Pennsylvania Department of Health to expand the service area and to obtain funds to expand to areas such as Delaware and Montgomery County. DHH was also reevaluating its advertising campaign on how best to reach out to the people who most needed help. They were prioritizing the use of paid Google Search over Google Display and dating apps. The switch in focus increased their contact click rate from 6.3% in July to 12.3% in August. They found people who clicked on paid Google search ads were more likely to self-schedule an appointment. He said DHH recruited more staff who manage the chat. They now have two digital navigators, two PrEP navigators, and a physician.

The next objective was to ensure access to Non-occupational Post-exposure Prophylaxis (NPEP or PEP). J. Williams reviewed the key strategies and activities. Activity 2.1 was to establish a centralized mechanism to distribute PEP through a PEP Center of Excellence. Activity 2.2 was to establish a new PEP partnership with the Pennsylvania and New Jersey Departments of Health. Activity 2.3 was to develop an initiative to address gaps in the provision of PEP including capacity, education, and resources that clients can use for follow-up.

J. Williams said he would take some time to speak about DHH's PEP Center of Excellence (COE). The RFP for the COE was submitted in July 2021. The award was made to Penn Medicine in October 2021. The POE included a jurisdiction-wide 24/7 PEP hotline operated by Penn Medicine. The COE had 3 brick-and-mortar clinical sites. He said there were streamlined, patient-centered workflows for business and after-hours. He said the client would be determined if they need PEP and they would be instantly connected with a doctor. He said the medical and navigational staff had awareness of and capacity to prescribe PrEP. DHH also had partnerships with Philadelphia FIGHT's Youth Health Empowerment Project (YHEP) and Prevention Point Philadelphia (PPP). J. Williams revealed statistics about how the program was used. To this date, there were 320 calls logged into the program. 145 callers were PEP eligible. 140 called and confirmed to have medicine delivered and the first dose taken. 114 callers attended an initial clinician office visit and 90 callers attended a 4-6 week follow-up clinician visit. 40 callers

transitioned to PrEP. J. Williams said the members may have noticed there were fewer people as they went through each step. He said the PEP COE allowed service if the client lived in Philadelphia or were exposed in Philadelphia. He said people who were exposed in Philadelphia could have started the PEP process in Philadelphia and then finished their process elsewhere. J. Williams said 15% of clients were exposed to HIV in Philadelphia but were not Philadelphia residents. Navigators follow up on multiple occasions and then recommend testing and PrEP in the individuals' hometowns. They provide a contact for local agencies if known and provide a link to the CDC resource finder if they could not find a local agency. Some clients were lost to follow-up but PrEP was discussed with all clients.

The presentation continued with goal 1, objective 3. The objective was to support perinatal HIV Prevention services for pregnant individuals. Objective 3.1 was to provide specialized case management for pregnant persons living with HIV. Objective 3.2 was to develop PrEP navigation support for pregnant HIV-negative people at risk of HIV acquisition. Objective 3.3 was to conduct case surveillance for people with diagnosed HIV infection and their infants. Objective 3.4 was to conduct perinatal HIV exposure reporting. J. Williams said activities 3.1 and 3.2 had been on hold since the funded agency was short-staffed. They had no perinatal case manager and the supervisor was on maternity leave. New staff were hired and were in training. These two activities were deferred until 2024.

J. Williams moved to goal 2; Objective 1 of the Prevent Pillar. The objective was to expand access to harm reduction supplies through novel approaches. Key activity 1.1 was to implement harm reduction vending machine intervention at pilot sites. J. Williams said they were placing Narcan and other harm-reduction supplies in the machines. However, they could not place safe injection supplies because it was considered paraphernalia and was not allowed in Philadelphia. Activity 1.2 was to ensure the availability of syringes at pharmacies by maintaining the Pennsylvania Department of Health's standing order. Activity 1.3 was to provide organizational development and capacity building to expand local partnerships and establish new organizations providing SSP services and new locations of service based on need and HIV public health data. Activity 1.4 was to expand the capacity for syringe programs to distribute and collect syringes at Ryan White HIV/AIDS Program-funded clinical sites. Activity 1.5 was to pursue the expansion of distributing syringes and other harm-reduction supplies in Emergency Departments and urgent care sites. Activity 1.6 was to engage with community members and stakeholders in program development and planning of harm reduction services through novel approaches to ensure they meet the needs of people who use drugs and avoid duplication of services.

Goal 2, objective 2 of the Prevent Pillar was to expand access to syringe service programs. Key activity 2.1 was to enhance linkage to substance use disorder treatment in SSPs. Activity 2.2 was to implement quality improvement plans as needed. Activity 2.3 was to provide more equitable SSP services geographically in Philadelphia. Activity 2.4 was to advocate for the implementation of SSPs in the counties in the jurisdiction outside of Philadelphia and in New Jersey counties in the EMA.

J. Williams then reviewed the objectives of Goal 3. J. Williams said this was pillar 0 and was woven into all the other pillars since eliminating disparities was important to the plan. The objective was to monitor local disparities along the status-neutral HIV continuum. Activity 1.1

was to continue reporting data by demographics and risk groups in the PDPH DHH HIV Surveillance Report. Activity 1.2 was to maintain a bi-annual update of the EHE dashboard, which includes HIV care metrics by demographics and risk groups. Activity 1.3 was to measure MSM/TSM perspectives on HIV testing and PrEP access to monitor disparities in access to testing/PrEP among these groups. J. Williams reported that all activities had been implemented. He said that activity 1.3 was being done through the National HIV Behavioral Surveillance (NHBS) and the DHH online PrEP consumer survey.

Goal 3 objective was to reduce HIV-related disparities in new diagnoses among the priority populations. Activity 2.1 was to expand new PrEP clinical-community partnerships to engage focus populations. Activity 2.2 was to continue City-wide distribution of free condoms, including in high schools, locations accessed by youth, and syringe service programs. Activity 2.3 was to expand the capacity of the HIV prevention workforce to provide primary HIV-related education. Activity 2.4 was to expand the promotion and distribution of community-specific sexual wellness and harm reduction information and supplies through innovative approaches. J. Williams reported on the progress DHH had made for this objective. PrEP provider workgroups continued to provide Primary HIV-related education. DHH was expanding its work with social media influencers through a partnership with a local media firm. DHH was continuing its distribution of condoms and sexual wellness supplies.

The third objective of goal 3 was to increase and support health promotion activities for HIV prevention in the communities where HIV was most heavily concentrated. Activity 3.1 was to continue the distribution of condoms in the jurisdiction. Activity 3.2 was to support media campaigns that advance HIV prevention and health promotion behaviors. Activity 3.3 was to encourage the provisions of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, People with intellectual disabilities (PWID), and people experiencing homelessness. In response to these objectives, DHH created a Health Equity Institute for their providers to allow providers to serve their communities with a culture of humility and sensitivity. DHH also had some ongoing media campaigns to promote HIV prevention and health promotion behaviors. J. Williams showed the HIPC members some of the advertisements. There were three advertisements. The first one promoted testing for HIV and STIs at home and provided a link to the PKOL website. The second advertisement had a similar message but was smaller. The third advertisement encouraged the public to test and test repeatedly. J. Williams had another version of the advertisements but in purple instead of pink. He then presented more ads that would be used in dating apps. They were similar to the silhouette ads he had shown earlier in the presentation.

J. Williams said he had finished his presentation and was willing to answer questions from the chat room. L. Diaz, the HIPC co-chair, said she would read the questions from the chat and would give J. Williams 10 minutes to go through the questions since they had co-chair elections and another presentation on the agenda.

The first question was from C. Steib. He asked where there was an age requirement for Telehealth services. J. Williams replied that the age requirements were ages 17 and up. A. Williams asked J. Williams to expand on the emerging partnerships with HC1. J. Williams said he could not answer that question. L. Diaz asked why he could not answer that question. J.

Williams said nothing was concrete yet regarding the partnership. He said the only thing he could reveal was that they were in talks with Dr. Asbel's team about tighter collaboration and more streamlined referrals. D. Jack asked if PKOL had a social media page such as Instagram. J. Williams replied that they did not have one yet. He said they were currently looking to upscale their social media presence, but they do not have a staff member in charge of this responsibility. J. Williams said they had more podcast content being published by the end of the month. J. Pipes asked where they could find the podcast. J. Williams answered if they would google the podcast, they should be able to find it on YouTube.

A. Williams asked about turnaround for receiving at-home resources after a client request. J. Williams said clients would usually receive them within 2-5 business days. He said these requests were fulfilled by one staff member. He stated that they would receive about 100 requests per week. If a person was in immediate need, he encouraged them to visit one of the low threshold sites which did not require an appointment or insurance. A. Williams asked how often PKOL's Resources Finder was updated. J. Williams said it was updated at least twice a year unless they were informed something was wrong. He said they also updated the resource finder if someone on one of their secret shopper calls got something wrong. He said they wanted to provide as accurate information as possible. B. Rowley asked about the target audience for the podcast. J. Williams replied that they had been filming the podcast since February but it had been inconsistent since J. Williams was the only person creating the podcast. He said they have been able to film every two weeks now that the podcast had resources for a team and he encouraged the HIPC members to join the podcast as a guest. He said the podcast was filmed at REC Philly in the Fashion District. He said they were still trying to figure out their target population since their target population was not likely to be searching for a sexual wellness podcast. He said they were currently focusing on evergreen content but would switch to content that targeted specific populations as time passed. D. D'Alessandro asked how they knew the person seeking PrEP was 17 years or older. J. Williams said if the person interested in PrEP was under 17 years old, they would be referred to a pediatrician. He said they had a partnership with the Children's Hospital of Philadelphia, St. Christopher's Hospital, and AEMC's pediatric department. For self-testing, the interested client self-reported their age. G. Grannan had a question about the 12,500 tests J. Williams had stated early in the presentation. He asked if those were the number of tests they used or the number of unique individuals they tested. J. Williams answered that it was the number of unique individuals who were tested because most people were tested on intake. He said D. D'Alessandro could verify his claims. D. D'Alessandro said they held a Health Federation discharge planning every other month. She said there could be duplicates if people were in prison more than once. She said they were tested with an option to opt out.

J. Williams was unable to answer the following questions which remained unanswered in chat:

1. Are there efforts to collaborate with existing PDPH infrastructure outside DIS?
2. Could you expand on the emerging partnerships with HC1?
3. Where can we find the addresses of these places (L-SHS)?
4. Was the PhillyKeepOnLoving prevention ecosystem driven by Radical Customer service?

-Second Quarter Spending Report-

A. McCann-Woods greeted the HIPC members and stated that the presentation would provide a summary of the reconciliation of total invoices forwarded to the Recipient (DHH) through August 31, 2023. The invoices revealed a total of $1,457,829, representing a 13% underspending in the EMA, including the Minority AIDS Initiative funds. A. McCann-Woods pointed out that expenditures through Q2 demonstrated that underspending was primarily due to staff vacancies throughout the EMA and delayed invoices. Furthermore, hospital sites and the fiduciary entities (Public Health Management Corporation and Urban Alliance Coalition) inherently had cumbersome fiscal processes, resulting in delays in submitting invoices and budgets.

Reviewing the Philadelphia portion of the report, A. McCann-Woods highlighted both underspending and overspending, with some exceeding the 10% threshold in the EMA region. The first service category was Substance Abuse, with an underspending of $70,798, representing a 28% underspending. A. McCann-Woods explained that this underspending was primarily due to vacancies and late invoicing. The next category was Medical Transportation, underspent by $3,429 or 59%, which she attributed partly to decreased utilization but mainly to late invoicing. Outpatient Ambulatory Care had an underspending of $480,625, equal to 21%, attributed to late invoicing, delayed spending on operating expenses, and clients leveraging other funding sources for the same service category. Medical Case Management showed an underspending of $526,210, accounting for 27%, primarily due to vacancies. Drug Reimbursement displayed an underspending of $95,245, or 41%, attributed to late invoicing and decreased utilization. A. McCann-Woods noted that clients had quicker access to Medicaid and SPBP.

Emergency Financial Assistance (EFA) in Philadelphia was overspent by $72,756, a substantial 314%. A. McCann-Woods attributed this to higher utilization. EFA-Pharma was overspent by $10,773 or 10%, mainly due to high utilization, and the increase in spending could be associated with patients being re-engaged in in-person care. EFA-Housing was overspent by $204,099, accounting for 103%, also due to higher utilization. Housing Assistance saw an overspending of $34,546 or 13%, primarily due to higher utilization. Food Bank services were overspent by $103,272, representing 103% overspending.

In the next section, A. McCann-Woods reviewed the second-quarter spending in the PA Counties. Oral Health was overspent by $25,426 or 27%, attributed to higher utilization. EFA was overspent by $10,754 or 79%, also due to higher utilization. A. McCann-Woods then examined underspending in the PA Counties. Outpatient/Ambulatory Health Care was underspent by $82,455 or 20%, primarily due to late invoicing, delayed spending on operating expenses, and clients leveraging other funding sources for the same service category. Medical Case Management showed an underspending of $77,861, accounting for 11%, attributed to vacancies. Substance Abuse Services displayed an underspending of $23,794 or 22%, attributed to vacancies and late invoicing. EFA-Pharma was underspent by $53,929 or 53%, with A. McCann-Woods explained that this was due to decreased utilization in the counties and SPBP linking clients quickly. She noted that this category historically underspends in this county. Medical Transportation was underspent by $51,848 or 26%, primarily due to late invoicing, delayed spending on operating expenses, and clients leveraging other funding sources for the same service category.

The HIPC members then reviewed spending in the New Jersey Counties. Food Bank services were overspent by $7,468 or 27%, which A. McCann-Woods attributed to higher utilization and carryover funds contributing to overspending, as those funds had to be used first. Outpatient/Ambulatory Health Care was underspent by $56,404 or 10%, primarily due to late invoicing, delayed spending on operating expenses, and clients leveraging other funding sources for the same service category. Medical Case Management displayed an underspending of $67,578 or 31%, attributed to vacancies. EFA-Housing was underspent by $39,321, accounting for 72%, and A. McCann-Woods noted that this was still under review as there were efforts to understand how New Jersey providers were making clients aware of the service.

A. McCann-Woods then reviewed the Systemwide Allocations spending. Information and Referral Services were underspent by $121,612 or 38%, primarily due to vacancies. Quality Management showed an underspending of $87,720, accounting for 31%, also due to vacancies. Capacity Building displayed an underspending of $52,264, representing 91%, which A. McCann-Woods attributed to vacancies and late invoicing. Planning Council Support was underspent by $108,737, accounting for 40%, primarily due to vacancies and late invoicing. Grantee Administration was underspent by $148,705 or 23%, attributed to vacancies and late invoicing. A. McCann-Woods explained that the cumbersome hiring practices and late contract conformance at the Recipient level resulted in this underspending. Medical Case Management was overspent by $174,301 or 25%, and A. McCann-Woods expected this to level out in the second half of the contract period, noting that this overspending usually didn't happen often.

A. McCann-Woods mentioned that the Recipient was still working on providing the HIPC members with a report on the two missing directives mentioned in the previous meeting. She expressed her intention to present this information at the November HIPC meeting to ensure they receive the full details.

Action Item
-Co-chair Election-
L. Diaz announced that they would proceed with the co-chair elections. She inquired with M. Ross-Russell if any nominations had been received since the last HIPC meeting. M. Ross-Russell confirmed that she had not received any nominations and mentioned that she had sought recommendations or expressions of interest from OHP staff, but they had not made any recommendations.

M. Ross-Russell reminded the HIPC members that individuals could only run for election if they were in good standing for at least a year. She defined 'good standing' as attending at least one HIPC meeting and one subcommittee meeting of their choice per month. She further clarified the limitations of the co-chair position, emphasizing that while a co-chair could provide information on a topic, they should not attempt to influence members toward a specific course of action, especially if it directly benefited them. The primary role of the co-chair is to facilitate meetings.

M. Ross-Russell asked S. Moletteri whether the vote for the co-chair would be conducted by a poll or through a roll call. S. Moletteri stated that they would conduct a roll call vote. She also pointed out that new members were not eligible to vote as their applications had not been confirmed by the Mayor's Office. M. Ross-Russell explained that the applications had been

submitted to the Mayor's Office, but they were awaiting a response and expressed gratitude for members' understanding and attendance.

S. Moletteri mentioned that the sole member running for co-chair was S. Heaven. S. Moletteri noted that S. Heaven would cast her vote on whether she would be re-elected as co-chair. After her vote and statement, she would be placed in a waiting room while the HIPC members discussed and voted on the matter. L. Diaz inquired whether she needed to abstain from the vote, to which M. Ross-Russell clarified that there was no need for her to abstain. S. Moletteri added that abstaining was not required since S. Heaven was not abstaining either.

S. Heaven introduced herself and expressed her deep passion for HIPC, mentioning her involvement since it was known as the Ryan White Planning Council in 1996. She described her background in housing and HIV Housing, particularly with the Housing Opportunities for Persons With AIDS (HOPWA) program. She highlighted her continued commitment to HIV housing, even as her professional role evolved. S. Heaven stated that she currently served as a contract administrator at the City of Philadelphia Division of Housing and Community Development. She said she switches roles to a co-chair when she attends meetings. She shared that her experience in HIV housing allowed her to contribute to HIPC in a unique way beyond her professional responsibilities.

After her statement, S. Heaven was placed in a waiting room. D. D'Alessandro inquired about any term limits mentioned in the Bylaws. M. Ross-Russell clarified that the term limits allowed for four consecutive 2-year terms and explained that the term limits were reset when the organization integrated. D. D'Alessandro asked whether this would be S. Heaven's third term, and L. Diaz clarified that this would be her second term. L. Diaz requested to vote last to avoid influencing any member's decision as the co-chair. S. Moletteri approved this request.

D. Jack: In Favor
L. Matus: In Favor
M. Cappuccilli: In Favor
A. Edelstein: In Favor
A. Williams: In Favor
G. Langan: In Favor
D. Surplus: In Favor
A. Scruggs: In Favor
D. Dalesandro: In Favor
G. Grannan: In Favor
C. Steib: In Favor
G. Keys: In Favor
S. Nieves: In Favor
K. Carter: In Favor
P. Gorman: In Favor
J. Baez: In Favor
L. Diaz: In Favor

Motion Passed: All in favor. S. Heaven was re-elected as co-chair of the HIV Integrated Planning Council.

Committee Reports:
-Executive Committee-
None.

-Finance Committee-
A. Edelstein said the Finance Committee had met last week and they had reviewed the spending report with A. McCann-Woods.

-Nominations Committee-
None.

-Positive Committee-
K. Carter announced the Positive Committee would have their first in-person meeting. He encouraged members to reserve their spots for the meeting. He asked S. Moletteri if the meeting would be hybrid. S. Moletteri replied that it was not.

-Comprehensive Planning Committee-
G. Grannan said the Comprehensive Planning Committee had met last month with the Prevention Committee. He said they would be meeting next week on October 19th.

-Prevention Committee-
C. Steib said the Prevention Committee would be meeting in combined meetings in November and December. He said their next meeting would be October 25th.

Other Business:
None.

Announcements:
C. Steib announced the Philly AIDS Walk was being hosted on Sunday in front of the Philadelphia Art Museum steps.

M. Woods announced that the Black Women PrEP Too campaign was underway.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** D. D'Alessandro motioned and C. Steib seconded to adjourn the October 2023 HIV Integrated Planning Council meeting. **Motion passed:** All in favor. The meeting adjourned at 3:47 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2023 Agenda (PDF)
- September 2023 Meeting Minutes (PDF)