Comprehensive Planning Committee
Meeting Minutes of
Thursday, October 19th, 2023
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Gus Grannan (Co-Chair), Debra D'Alessandro (Co-Chair), Gerry Keys, Pamela Gorman, Adam Williams

Guests: Gita Krull-Aquila (DHH), Laura Silverman (DHH)

Excused: Keith Carter

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

Call to Order: D. D'Alessandro called the meeting to order at 2:04 pm.

Introductions: D. D'Alessandro asked everyone to introduce themselves.

Approval of Agenda:
D. D'Alessandro referred to the October 2023 CPC agenda and asked for a motion to approve. **Motion:** G. Keys motioned; A. Williams seconded to approve the October 2023 Comprehensive Planning Committee agenda via a Zoom poll **Motion passed:** 5 in favor. The October 2023 CPC Committee agenda was approved.

Approval of Minutes (*September 27th, 2023*):
G. Grannan referred to the September 2023 Comprehensive Planning Committee/Prevention Committee Minutes. **Motion:** G. Keys motioned; G. Grannan seconded to approve the September 2023 Comprehensive Planning Committee/Prevention Committee Meeting Minutes via a Zoom poll. **Motion passed:** 2 in favor, 1 abstaining. The September 2023 Comprehensive Planning Committee/Prevention Committee Minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
S. Moletteri stated that the meeting would be relatively short since they were only going to review some planning material. She asked the committee if they were comfortable combining their meeting with the Prevention Committee's meeting next month. She informed the committee that the Prevention Committee's meeting was scheduled near a major holiday, which was why

they were considering a joint meeting. She mentioned that the decision would need to be discussed by the co-chairs before being finalized. They needed to determine whether there was enough time allotted to each committee's topic if they chose to combine the meetings. D. D'Alessandro said she had no objections to the idea and reminded the committee that the next CPC meeting would be held on November 16th. A. Williams, who attended both committee meetings, said he had no objections to the idea. G. Keys agreed with the idea, and S. Moletteri stated that they would bring the idea to the joint co-chair meeting.

D. D'Alessandro inquired about how they fared with the in-person Prevention Committee meeting. S. Moletteri said they had the in-person meeting with the Positive Committee. She reported that attendance at that meeting was sparse and believed it would continue to be so until people were more comfortable with in-person meetings. She mentioned that attendance in the Positive Committee was usually sparse and that they were looking to improve it by recruiting new members or reaching out to old members. D. D'Alessandro said the hesitation to return to in-person meetings was understandable. S. Moletteri agreed and mentioned that, though they tracked member attendance in the Nominations Committee, they remembered that all the members were volunteers.

Presentation:

–QM Update by the Division of HIV Health–

L. Silverman greeted the committee and introduced herself as the Quality Advisor at the Division of HIV Health (DHH). She was also the Comprehensive Planning Council representative for DHH. She arrived at the meeting with her colleague, G. Krull-Aquila, the Quality Management Coordinator at DHH. L. Silverman reminded the committee that they had presented the Quality Management (QM) Plan in March 2023 and had received feedback from the various committees of the HIV Integrated Planning Council (HIPC). She said they had returned to provide an update on the plan with the feedback they had incorporated.

The first goal reviewed in the presentation was to evaluate, build upon, and expand Clinical Quality Management infrastructure and activities supporting the End the Epidemic (EHE) goals. Objective 2 under goal 1 was to apply a Quality Improvement (QI) perspective to review and provide feedback on Corrective Action Plans (CAPs) submitted from providers with identified issues during the bi-annual DHH appointment availability calls. L. Silverman said they had added two new action steps to the objective. The first action step was to analyze appointment availability call data to see if first appointments were offered within 4 business days to align with immediate antiretroviral therapy (iART). The second action step was to incorporate information about linguistic services into the systems-level appointment availability call summary report and eligible metropolitan area (EMA) report. L. Silverman said they would still look to see if the third appointment was created before 15 days, and now they would include the 4 days for the first appointment. The fourth objective was to initiate Quality Improvement Projects (QIPs) with DHH-funded Prevention, Medical Case Management (MCM), and outpatient ambulatory health service (O/AHS) programs using a coaching model to improve performance across identified areas. The new action step added was to explore additional ways to include consumer feedback

in QIPs. She said they had already looked for consumer feedback at the start of a project and were looking for additional ways to incorporate consumer feedback into their projects.

Goal 2 stated that they were aiming to improve coordination between O/AHS and MCM providers to support the linkage and retention of clients in care. The third objective for this goal was to develop an evaluation process to measure the referral of unsuppressed O/AHS clients to MCM services. DHH added two new action steps based on the feedback. The first action step was to gather information during the new QIP cycle from O/AHS providers on how People Living with HIV (PLWH) were assessed for the need for MCM. The second action step was to obtain information from O/AHS providers during the new QIP cycle on the type of information they gather on PLWH's satisfaction with visits. Objective 5 was to establish a process to improve coordination between O/AHS and MCM services. The new action step that was added was to reconvene the MCM workgroup. She said they were hoping to start the workgroup again soon.

L. Silverman ended her presentation and asked if the committee had any questions. S. Moletteri said she remembered that clients called the Spanish line for appointment availability call service and the person receiving the call was unable to provide services because of a language barrier. She asked for more information on the progress to rectify the linguistic issue. L. Silverman explained that for the last call cycles they performed, they performed half in Spanish and half in English. She acknowledged that they were having more difficulty with the Spanish language calls. G. Krull-Aquila mentioned that they had been receiving more requests for assistance and more appointments with the interpretation service they use. D. D'Alessandro asked if there were any other questions. There were no more questions from the committee.

Discussion Items:

–Parking Lot Discussion–

S. Moletteri said the parking lot discussion topics were taken from the allocations meetings. The HIPC members did not have enough time to discuss these topics during the allocations meetings and wanted more information about them. The parking lot discussions were on the agenda for the last few meetings but had to be tabled due to time constraints until this meeting. S. Moletteri said she would read the questions and the questions she had given DHH, the recipient. She submitted three of the four topics. The first question was not submitted to DHH but asked DHH to investigate how individuals 50+ years of age best receive information by looking at common practices for providing information to aging populations. She said this topic had been at the forefront of their meetings. She said they had recently had a presentation about aging with HIV. The topic was about how to support those aging with HIV and how to procure information from them that would help them understand their situation. S. Moletteri said this was a topic that DHH could not help with, but it was a topic that they could discuss internally. D. D'Alessandro said A. Thomas-Ferraioli just held a listening session for those aging with HIV. D. D'Alessandro said she did not attend the meeting and had only heard about it from the Health Federation. She said it could be useful to contact A. Thomas-Ferraioli for more information. She also suggested that those over 50 were too large of an age group and should be further broken down. She said a person who was age 70 may have different access to resources than a person who was age 59. She added that they should include researchers who may be exploring the topic. T. Dominique

said she was willing to do a literature search to see if there were any researchers exploring these topics. D. D'Alessandro said she would try to reach out to A. Thomas-Ferraioli to see if the topics were covered in the focus group.

The next topic was the breakdown of spending for activities within Substance Use Services (Outpatient), specifically drug testing. S. Moletteri said she had sent this question to the recipient with a request to ask how much funding was allocated for the services without identifying the organizations performing the services. D. D'Alessandro asked if G. Grannan would like to comment since this topic was one he was concerned about. He said the topic was acceptable and that he was eagerly awaiting the data.

The third topic was the investigation of transportation method utilization, specifically those using the free SEPTA program for individuals age 65+ as well as reduced fare for those with social security and disability. S. Moletteri said SEPTA was out of their jurisdiction, but she did reach out to the recipient to request information about which mode of transportation the target population was using. She mentioned that they could look into contacting SEPTA for more information. S. Moletteri said T. Dominique did provide information about the SEPTA fares. She then read the information that T. Dominique provided. S. Moletteri read that the Zero Fare SEPTA program would provide 25,000 keycards for financially vulnerable passengers that were valid roundtrip for up to 1 year. S. Moletteri said that based on factors such as age and income, 90% of participants at random would automatically be enrolled in the program. The last 10% of keycards would be reserved for Community-Based Organizations (CBO). S. Moletteri asked T. Dominique to provide the link to the SEPTA website to the committee. T. Dominique provided the link to the website and the phone number. The phone number was 215-686-4419, and the site was the Zero Fare page on the City of Philadelphia website. D. D'Alessandro asked if the program worked like a lottery. S. Moletteri confirmed that it did.

The last topic in the parking lot ideas was a request to look into Mental Health services utilization. S. Moletteri said there was an increase in spending and utilization in Philadelphia. S. Moletteri said she sent in the request to DHH asking for more information on mental health services utilization in Philadelphia and that she knew there was increased spending utilization. She wrote that the following information could be useful to the CPC:

- Personal Insurance versus Ryan White Insurance coverage
- Average number of visits per client
- TeleHealth versus in-person visits

She had also asked DHH for recommendations or any useful information that could be beneficial due to the increased spending and utilization. S. Moletteri then asked the committee members if there were any other requests or information they would like to know. T. Dominique asked S. Moletteri to define Mental Health services in terms of the range of services. S. Moletteri said she was thinking of therapy such as one-on-one therapy or a group session. M. Ross-Russell said the definition would depend on what it is that they pay for, the availability of what is paid for, and

what information DHH has access to. S. Moletteri read the Health Resources and Services Administration (HRSA) definition for mental health services:

"Mental Health services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists and licensed clinical social workers."

S. Moletteri emphasized that licensed individuals were important in the definition and peer-led groups were not included. She said they would be receiving more information in November.

Other Business:
A. Williams said he had pressing concerns from last week's HIPC meeting. He said he had concerns about the recipient's data on diagnostics for HIV screenings. He said it was clear and understandable why the recipient would favor expanding access to opt-out lab-based screenings. Overall, he felt it was a good choice but disagreed that expanding access should come at the expense of rapid test screening. He was also concerned about how the data was presented and the inferences that were made about rapid test screenings or non-lab-based screenings. He felt that DHH was not upfront with the information they were presenting. He referenced a slide that compared the rate of diagnosis between the two types of tests. A. Williams said there were statistical fallacies. For example, he said rapid tests needed to be confirmed by lab-based screenings, and this resulted in a higher rate of diagnosis for lab-based screenings. He said in this case, a positive rapid screening implies that rapid screenings were finding more patients than opt-out tests were not. He said he found out DHH had described rapid testing as a waste of money and disrespectful. He said discarding rapid tests as an option due to lack of funding or otherwise would only perpetuate racial and ethnic disparities and cause reverberating consequences that enforce systemic bias and barriers to care. A. Williams said he had issues with how DHH had dismissed some of the questions. He said it was not appropriate for the recipient to refuse to answer a question about data or the plans they present. He said it was their role to advise HIPC. He asked how they could fulfill their role if the recipient refused to share details related to their shared goals.

D. D'Alessandro agreed that A. Williams brought some very important concerns. She asked if DHH provided the slideshow from the presentation that A. Williams was referencing. S. Moletteri said they had not received the presentation. D. D'Alessandro asked the committee to comment on the situation. G. Grannan said this was the logical result of focusing on clinical means and ignoring community-based means. He said one of the benefits of rapid testing was building relationships and community. He said once clinical issues arise, the community-building aspect can help the person delivering care and the person navigating the healthcare system arrive at the most useful place for the person at risk. He agreed that A. Williams brought forward valid points. He said clinical services were important but they could not be the only option to serve impacted communities. He gave an example that syringe service was impactful in emergency

rooms but it should not be the only place where there is syringe distribution. M. Ross-Russell said she was in the process of following up on the questions that were posed at the last HIPC meeting. She said she had not wanted to reveal anything until she had more detailed answers. She said she learned that rapid tests were still being used in the prisons and at status-neutral community-based sites, and low-threshold sexual health sites (L-SHS). She said pharmacies had self-tests. She said that CDC-funded sites could still have rapid tests but the CDC recommended lab tests even in community settings. She said that was a partial answer and that it was another question that she was following up on tomorrow. P. Gorman said she agreed that having a method at the expense of another method of testing was not good. She said it would be helpful to have the presentation slides because she was a visual learner. P. Gorman asked if they could have A. William's questions in writing. D. D'Alessandro said A. Williams had already restated his questions in the chat. A. Williams wrote:

> "I asked questions including why DHH seems to be focusing on improving their collaborative work on the state level but not reinforcing their work within the infrastructures of city agencies. I asked about why PDPH AHS health centers are not included on Phillykeeponloving.com resources. I asked for the recipient to expand on what they meant by 'exploring a relationship with Health Center 1.'"

A. Williams said that part of the reason why his questions had gone under the radar was that the presentation itself avoided the words "rapid testing." He believed that the "rapid testing" was not even said once. He was concerned that DHH was trying to intentionally conceal that they were talking about rapid testing when they mentioned rapid tests as "other tests." He said it was ridiculous to favor clinical-based screenings since there were so many patients who didn't receive lab work during their medical visits. He said he had worked at the AHS and he noticed that people do not always stay for their labs to get them done. He feared that DHH's path would be harmful to their goals in ending HIV.

D. D'Alessandro said the CDC had prioritized not paying for the tests. She said it had been a stated message during meetings for years. She said the CDC had wanted people's insurance to pay for the tests and avoid using CDC funding. She said if people were moved towards lab-based testing, the test would be billed to the person's insurance if they had insurance rather than the CDC. She said she was assuming good faith in how the data was reported. She believed that DHH's hands were tied by funding. She felt that the lab-based testing decision was driven by CDC funding. A. Williams said it does not change the fact that the change would disproportionately impact neglected and mistreated communities throughout the city and throughout the nation. A. Williams said it was their responsibility to push back against these ill-advised ideas.

M. Ross-Russell said the presentation from the HIPC meeting was presented first at a different meeting. She said it likely was updated and then streamlined for the HIPC meeting. The presenter for both meetings was the same person. She said it was likely that the data was presented the way that it was in the HIPC meeting. D. D'Alessandro thanked A. Williams for his honesty and perception. M. Ross-Russell said she would augment her follow-up with the additional information that she had received in this meeting.

D. D'Alessandro asked if they had plans for the December CPC meeting since it was near a major holiday where people were likely to be using personal time off. S. Moletteri said they currently do not have a concrete plan yet. S. Moletteri said they could discuss this during the co-chair meeting.

Announcements:
None.

Adjournment:
D. D'Alessandro called for a motion to adjourn. **Motion:** A. Williams motioned, and P. Gorman seconded to adjourn the Comprehensive Planning Committee meeting. **Motion passed:** Meeting adjourned at 3:06 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2023 Meeting Agenda
- September 2023 Comprehensive Planning Committee/Prevention Committee Minutes
- FY 2024 Parking Lot Document