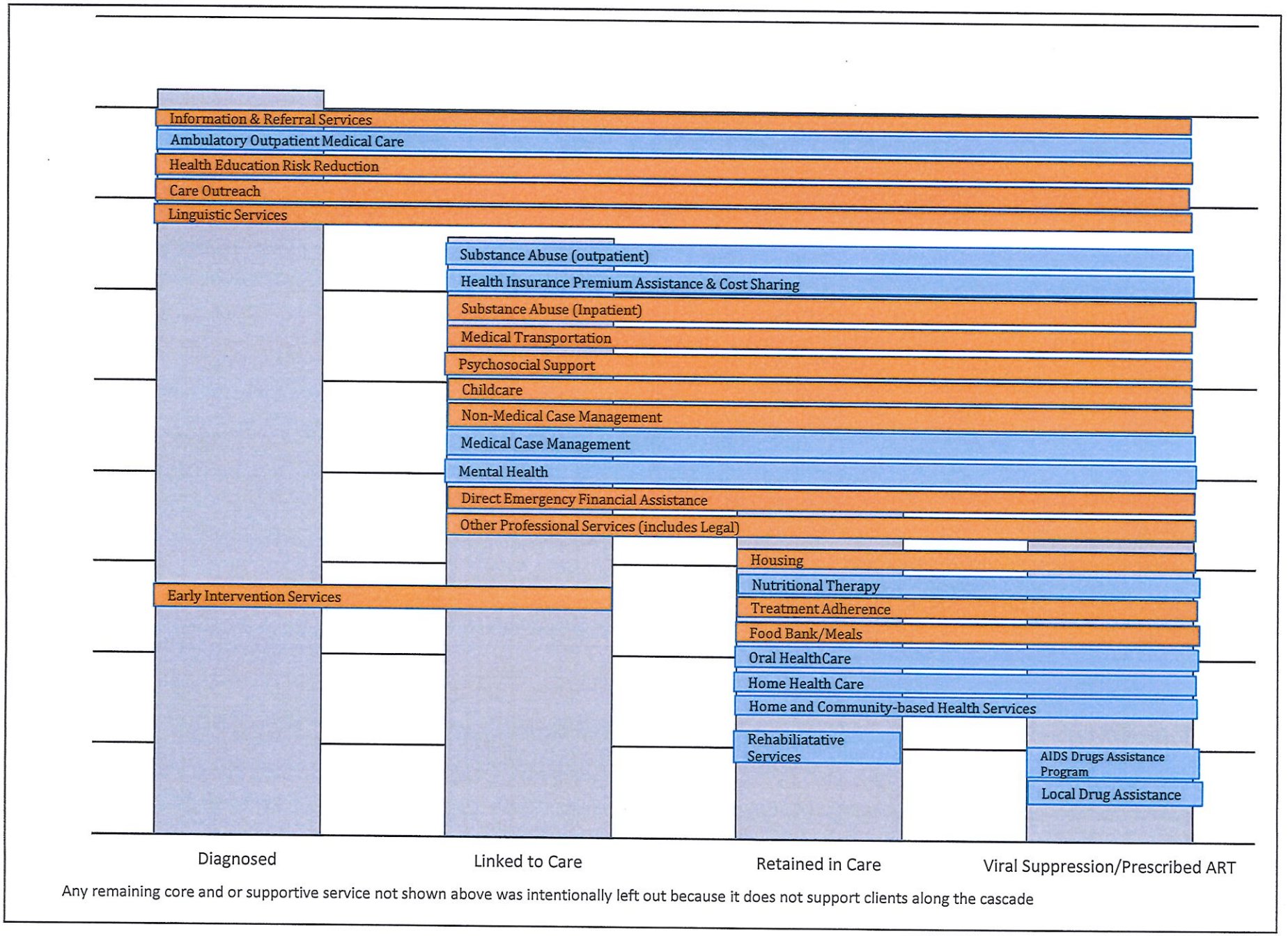
Service Priority Setting Worksheet 2019

Each service category will be scored according to these factors and scales using the sources noted for each factor. For the Community Voices factor each individual will vote their conscience and scores will be tallied by the average of those scores.

Factor	Definition	Scale
Consumer Survey (20%)	Percentage of consumers who said they used or "needed but didn't get" in the last 12 months, in the 2017 Consumer Survey.	1- 0-15% 3- 16-30% 5- 31-45% 8- 46%
Medical Monitoring Project (20%)	Medical Monitoring Project data captures unmet service needs for PLWH in care. It is a representative sample of PLWH in HIV care.	1 – no mention 3 – 1-14% 5 - 15-44% 8 – 45%
Client Services Unit-Need at Intake (20%)	Self-reported service need to Client Services MCM intake. These individuals are re-entering or entering the RW service system.	1 – no mention 3 – 1-24% 5 – 25-49% 8 – 50%
Community Voices (40%)	This factor seeks to quantify community opinion/expertise of delivering and receiving HIV services in relationship to emergent needs and issues, vulnerable populations, community knowledge, and other EMA data.	1- this service is needed to ensure engagement in care, retention in care and/or viral suppression 5- This service is important to ensure engagement in care, retention in care, and/or viral suppression 8- This service is critical to ensure engagement in care, retention in care and viral suppression.

Gaps in Service as Reported by Consumers by Percent

Service Reported as Needed	PDPH Client Services Unit Need at Intake (n=1,976)	Medical Monitoring Project (n=166)	EMA Consumer Survey (n=392)
Medical Care	26.5	4.2	3.8
Medications	22.1	1.5	3.8
Treatment Adherence	40.9	1.9	9.9
Dental	3.8	45.1	11.2
Home Health Care	1.8	N/A	11.2
Mental Health	21.6	9.7	10.5
Case Management	N/A	15.7	5.9
Substance Abuse Treatment	4.9	2.7	8.7
Food	23.5	6.5	9.9
Housing	50.1	16.0	15.1
Transportation	22.8	12.5	11.2
Support Groups/Peer Support	4.8	8.0	9.4
HIV Education/Risk Reduction	10.1	N/A	N/A
Benefits Assistance	40.2	18.4	11.7
Language Translation	2.0	0.0	10.5
Patient Navigation	N/A	2.3	7.9



Any remaining core and or supportive service not shown above was intentionally left out because it does not support clients along the cascade

COMPREHENSIVE PLANNING COMMITTEE

MEETING AGENDA

Thursday, March 21, 2019

2:00 – 4:00PM

Office of HIV Planning 340 N. 12th Street Suite 320
Philadelphia, PA

Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*February 21, 2019*)

Report of Staff

- **April Meeting**

Report of Chair

- **Co-Chair Election**

Discussion Item

- **Finalize Priority Setting Process**

Old Business

New Business

Review/Next Steps

Announcements

Adjournment

PLEASE TURN ALL CELL PHONES TO SILENT.

*The next **TENTATIVE** meeting of the Comprehensive Planning Committee is **April 25, 2019 from 2 to 4 pm** at 340 N. 12th Street, Suite 320, Philadelphia, PA 19107. **Please refer to the Office of HIV Planning calendar of events for committee meetings & updates (www.hivphilly.org). If you require any special assistance, please contact the office at least 5 days in advance.***

Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, February 21, 2019
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Adam Thompson, Keith Carter, Dave Gana, Mark Coleman, Tiffany Dominique, Janice Horan, Leroy Way

Excused: Gerry Keys, Peter Houle, Pam Gorman, Nicole Miller, Gail Thomas

Absent: Terry Flores-Sanchez, La'Seana Jones, Jeanette Murdock, Joseph Roderick, Gloria Taylor, Lorrita Wellington

Guests: Jessica Browne (AACO), Julio Jackson

Staff: Nicole Johns, Dustin Fitzpatrick

Call to Order/Moment of Silence/Introductions: A. Thompson called the meeting to order at 2:07 p.m. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: D. Gana moved, general consensus to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes *(January 17, 2019)*: A. Thompson presented the minutes for approval. **Motion**: D. Gana moved, J. Jackson seconded to approve the January 17, 2019 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
T. Dominique stated that this is her second to last meeting and that they need to find a new co-chair. N. Johns informed the members that they are in charge of their own Committee leadership. A. Thompson suggested they wait until the March meeting and vote on it then. A. Thompson discussed reaching out to G. Keys since she has been a Co-Chair before.

Report of Staff:
N. Johns informed members that she will not be here for the April 18th meeting and suggested that the Committee reschedule to April 25th. A. Thompson proposed this to the Committee and everyone agreed to tentatively make it April 25th from 2 to 4 PM. They will revisit this at the March meeting since several members were not at this meeting.

N. Johns explained that OHP staff are open to suggestions for reorganizing the conference room. She informed them that OHP will start making tools for members to learn acronyms and other relevant information to help with priority setting and

allocations. Members are welcome to suggest things to help decorate. A. Thompson talked about reaching out to schools for art for the conference room.

Discussion Items:

Priority Setting Process

N. Johns stated that the Committee should start with the service priority setting worksheet. She reminded members of what they discussed in the last meeting on January 17th (see last month's minutes). She explained to members that she highlighted the percentages under scales column in Medical Monitoring Project (MMP) and Client Services Unit- Need at Intake (CSU). She informed members it was up to them whether they want to continue using the scale or use a different one. She stated that in the current scale there are a lot of 3s and 5s. She suggested making the criteria for the 8 a little lower since most of the services did not go past the 50% mark as seen in the Fig. 11: Gaps in Services as Reported by Consumers by Percent table.

N. Johns explained to members that they may want to take a look at the Community Voices category. She informed members that they can rename it and reexamine the scale used in that category; N. Johns used the last Committee meeting's discussion for description of the numbers. She stated that members can add a 3 in there if they wanted to. M. Ross-Russell made a new spreadsheet with the new factors they came up with using the 2017 scores gathered so that members can see how their changes would influence those scores. N. Johns projected the spreadsheet in the front of the room.

N. Johns explained to members that she highlighted the service categories that had a 5 place difference in position, which are:

- Emergency Financial Assistance/Medications (moved from 14 to 7)
- Child Care Services (moved from 18 to 12)
- Ambulatory Care (moved from 3 to 18)
- Day or Respite Care (moved from 29 to 22)
- Information and Referral (moved from 20 to 26)

N. Johns raised the concern that Ambulatory Care decreased by a significant amount. A. Thompson inquired if this was because CSU did not identify this as an unmet service need. N. Johns responded that CSU did identify this as an unmet service need, whereas the MMP did not. A. Thompson clarified that this was because the MMP examined PLWH in care. N. Johns explained to members that some of the service categories were not named in the CSU or the MMP. She stated the way that some of them are captured on the table could be a lot of different service categories. As an example, she suggested that Benefits Assistance could capture the Legal Services category because it helps PLWH access health insurance benefits.

N. Johns suggested that members may want to change some of these scores; she mentioned that some of these categories get lost because they do not get mentioned. A. Thompson asked J. Browne if there was another data set that highlights the service categories if they do not get mentioned in either the CSU or the MMP that they could substitute in. J. Browne suggested that they could use utilization data. A. Thompson

agreed that it was a good idea. He explained that Ambulatory Care dropped down because everyone uses it, so therefore, would not be mentioned as an unmet need. Thus, utilization data would be important to have to explain this. N. Johns informed members that in previous years, they either assumed Ambulatory Care as number 1 or they removed it from the ranking process. She suggested that members could do that with any number of the services. She stated that they are required to have it on the list, but if they feel a service category is not adequately captured for what they know, they can provide reasoning as to why they feel it should be ranked differently.

J. Jackson inquired if the statistical data utilized represents all the needs of the PLWH in order to generalize these services into categories. A. Thompson clarified that these are statistical samplings and that they used a good sample of PLWH. J. Jackson explained the reason that he asked about is because he has concerns about the needs for PLWH that are not in care and may not adequately be represented. N. Johns stated that in particular, the CSU represents the needs of PLWH because this is self-reported by individuals entering or re-entering the RW system. She also referenced the Fig. 11 table, highlighting the sample size of the CSU was 1,976 in comparison with the MMP's 166 sample size. A. Thompson inquired whether the sample size of the MMP is representative nationally or just Philadelphia. T. Dominique responded that it was just Philadelphia.

A. Thompson discussed how Ambulatory Care dropped, but Health Insurance Premium and Cost Sharing Assistance went up from 7 to 2. He stated that other areas have done this and that their assumption is that people will have access to Medicaid/Medicare or employer health insurance.

T. Dominique returned to what J. Jackson brought up and stated that the city is collecting data on people who are lost to care for more than a year (CoRECT). N. Johns explained to members that she wrote some examples of data available on the white board, which include:

- EMA Care Continuum – subpopulations for Philly (disparities)
- Rates of retention and viral suppression
- EMA PLWH insurance status and income
- Barriers to care among PLWH out of care (CoRECT)
- Comparison of outcomes for RW/all PLWH by MAI pops and others
- RW PLWH disparities in viral load suppression (RW HIV outpatient data)
- Service utilization data by insurance, age, race/ethnicity, region, gender
- RW outcome measures by service
- Other consumer survey data and focus group results

She stated that she thought this would more so inform the Community Voices section.

A. Thompson reminded members that just because something dropped on the list does not mean that it changes the funding allocations. N. Johns explained to the Committee that funding should not have any impact on this list. K. Carter was confused about what the data was representing. A. Thompson explained to members that in addition to this list, there will be utilization data brought to these allocations meetings. He suggested for the

case of Ambulatory Care, utilization data would demonstrate why they feel funding should continue as is even if it is not ranked on the unmet need list.

A. Thompson inquired whether the Essential Health Benefit (EHB) category is useful when not everybody has access to health insurance. He inquired if it was meaningful to the people they are trying to serve and suggested they could instead they use utilization data to help with the ranking process. He stated that Ambulatory Care would be higher on the list and utilization data would allow them to capture that. N. Johns noted that there are 28 services on the list and only 12 are funded, meaning there will not be utilization data for the unfunded services. She suggested members keep that in mind. A. Thompson suggested moving EHB into the Consumer Survey category; all three of the quantitative data sources would be balanced the same way each given the weight of 20%. Then the Community category, with the qualitative and quantitative review, would weigh at 40%. Then he suggested the utilization data would be brought up during the allocations meetings.

A. Thompson inquired if the allocations process would be in the purview of Comprehensive Planning Committee or if it is just something Finance Committee works with. N. Johns stated that historically that utilization data has been a part of the allocations process, which Finance Committee oversees.

K. Carter asked about the number of services funded. N. Johns informed members that there really has not been much of a difference in the number of services funded in Part A in the EMA for several years.

T. Dominique stated that the EHB is necessary because not everyone is covered as A. Thompson previously stated. He asked what EHB bearing has on people without insurance. Through the EHB, they primarily are talking about health insurance through Obamacare and the changes that made for what services that would be covered. A. Thompson stated they looked at services that are covered by EHB and ranked things lower because it was already covered by Obamacare. They ranked things higher if it was not covered. A. Thompson suggested that their focus should be on people who do not have health insurance.

M. Coleman inquired about the section of Community Voices and whether they factor in the trends and data. He wondered how this can be possible if the community does not understand the diversity of the people within the community. N. Johns responded that the Committee is here to represent the different facets of the community and to incorporate the various trends and data. She suggested that the key is to get more and different groups of people involved in the Committee in order to address M. Coleman's concern.

J. Jackson stated that the Committee should be reaching out to people instead of just making decisions for them. T. Dominique explained that the OHP put together a consumer survey and that it was sent out to clients in order to understand the needs of others. She stated that as HIPC members, they should be bringing community voices too.

A. Thompson discussed how MMP is purely the clinical eye by going through medical records and performing interviews to gather more information. The CSU is people reaching out to AACO and detailing their own needs, while the Consumer Survey was sent out to PLWH to gather information from the community. He stated that this is why he thinks they should get rid of the EHB and weigh the Consumer Survey more. A. Thompson explained to J. Jackson how they use the data to inform members before voting on something. N. Johns agreed. J. Jackson reiterated that he just wants to be sure that all community voices are being captured before making decisions.

J. Browne suggested that trainings on different service categories would be beneficial because some people may think that Housing Assistance means that they provide housing to people, which is not the case. N. Johns agreed that it is a good point because there are multiple layers to service categories. There is what the federal government allows to be done, but then there is what it actually looks like in the EMA. A. Thompson suggested that it may even be beneficial to state what the services do not entail to clear up possible misconceptions. J. Jackson inquired if the people making these decisions have any experience or knowledge of the needs of the community. N. Johns informed him that these decisions are made by the people sitting in this Committee.

A. Thompson informed members that this Committee and the HIPC has a lot of power in what is allocated where and the services that are provided because it is backed up by federal law. N. Johns informed the Committee that the money follows the epidemic. K. Carter was confused by this and inquired what exactly it means, especially when people of color have not seen the same progress. A. Thompson responded that federal funding really comes down to how many PLWH there are in the EMA and if the prevention plan is working and that number decreases, then funds will decrease as well. He explained that the South did not receive a lot of funding in the beginning of the epidemic because the number of people living with AIDS (PLWA) was used to determine funding. Major cities had more of that population so therefore the funding stayed in major cities, until recently.

Returning to the task at hand, the Committee eventually came to general consensus to remove the EHB and add that 10% to the Consumer Survey. The members then discussed having the rankings of 1, 3, 5, and 8 capped at 50% since the service need data only reached up to 50%. This would result in getting more service categories to have a higher score and therefore may more accurately represent the identified unmet service need.

J. Jackson asked how long does the budget last. Members informed him it is yearly. A. Thompson asked members if it made sense to keep 8 being whatever the highest number is. So there will only be one 8 because 8 will represent 50% and above. The questions are does the scale 1, 3, 5, and 8 make sense and what are these numbers mean now? N. Johns suggested that something about vulnerable populations should be added to the language involving the ranks.

A. Thompson suggested that putting 1 at "needed", 3 at "critical", and 5 at "critical and vulnerable". He stated that 8 can be "need is critical and affects vulnerable populations and there is a disparity".

J. Jackson asked about prevention techniques and how to keep young MSM from acquiring HIV. A. Thompson responded that allocations for the RW system is focused on PLWH, not HIV prevention service funding.

T. Dominique suggested that 8 should be "and" as in that "need is critical and affects vulnerable populations and there is a disparity". She stated that 5 can be "or" as in "need is critical or affects vulnerable populations".

A. Thompson wrote on the board another suggestion for the scale. 8 could be "need is critical and disparity data exists", 5 could be "a more critical service", 3 could be "a more important service", and 1 can be "no change". He advocated for this because they are already looking at a previously ranked list to make this decision. N. Johns asked what critical means in this context? She inquired if the goal is viral suppression. Members deliberated on this for a while and came to the consensus that the goal should be suppression, retention, and engagement.

A. Thompson suggested that the Committee could not look at what had previously been done and instead look at what the community and what the data states. T. Dominique suggested getting rid of the 3 because having 4 categories was making it hard. 1, 5, and 8 can have language surrounding suppression, retention, engagement since this was the agreed upon goal. 1 now represents "needed for suppression, retention, and engagement", 5 represents "important for suppression, retention, and engagement", and 8 represents "critical for suppression, retention, and engagement". T. Dominique asked if the Committee has ever not considered what the other scores are when determining subjective scores. N. Johns stated no because it had not used a combination of subjective with objective in this way. N. Johns stated that they can do this first and that if people want to look at the numbers, they can.

A. Thompson raised the concern of providing too much information to members and overwhelming them. He suggested that they only look at a few of the examples of what N. Johns had listed on the board. She and members agreed.

Racial Equity Workgroup
N. Johns informed members that no one had expressed interest in participating in the workgroup. She explained that M. Ross-Russell suggested that the Comprehensive Planning Committee can take it up on their own and delegate to other committees in the fall after allocations.

Old Business:
None.

New Business:
None.

Announcements:

T. Dominique stated that Anthony Fauci will be presenting at a listening session at UPenn on February 22nd about emerging infectious diseases.

Adjournment: The meeting was adjourned by general consensus at 4:07 p.m.

Respectfully submitted by,

Dustin Fitzpatrick, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- Service Priority Setting Worksheet 2019
- Racial Equity Workgroup Purpose and Scope
- Fig. 11: Gaps in Services as Reported by Consumers by Percent table
- Fig. 4: Non-Concurrent and Concurrent HIV/AIDS Among Incident HIV Diagnosis by Race, Gender, Age and Transmission Risk, 2016