COMPREHENSIVE PLANNING COMMITTEE

MEETING AGENDA

Thursday, May 16, 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 (*March 21, 2019*)

Report of Staff

Report of Chair

- **Co-Chair Election**

Discussion Item

- **Finalize Priority Setting Process**
- **Preparations for Regional Allocations**

Old Business

Racial Equity Work Group

New Business

Review/Next Steps

Announcements

Adjournment

PLEASE TURN ALL CELL PHONES TO SILENT.

The next meeting of the Comprehensive Planning Committee is ***June 20, 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, March 21, 2019
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Tiffany Dominique, David Gana, Gerry Keys, Joseph Roderick, Adam Thompson,

Excused: Peter Houle, Leroy Way.

Absent: Mark Coleman, Terry Flores-Sanchez, Pamela Gorman, Janice Horan, Le'Seana Jones, Nicole Miller, Jeanette Murdock, Gail Thomas, Lorrita Wellington.

Guests: Jessica Browne (AACO), Julio Jackson

Staff: Nicole Johns, Dustin Fitzpatrick

Call to Order/Moment of Silence/Introductions: T. Dominique called the meeting to order at 2:11 p.m. Those present then introduced themselves.

Approval of Agenda: T. Dominique presented the agenda for approval. N. Johns asked if the committee wanted to revisit the Racial Equity Workgroup under Old Business **Motion**: K. Carter moved, D. Gana seconded to approve the agenda as amended. **Motion passed**: All in favor.

Approval of Minutes *(February 21, 2019)*: A. Thompson presented the minutes for approval. **Motion**: K. Carter moved, D. Gana seconded to approve the February 21, 2019 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
Co-Chair Election
T. Dominique inquired if the committee could function with one chair, because she would be leaving the Planning Council at the end of March. N. Johns stated that the committee has to have at least one chair, which they do. She suggested tabling this election until the April committee meeting in order to get the ideas and buy-in from more members. The committee agreed to wait after discussing possible candidates.

Motion: K. Carter moved, D. Gana seconded to table the committee co-chair election until April. **Motion passed by general consensus.**

Report of Staff:
Listening Sessions
N. Johns informed members of the Listening Sessions for April in Media and Levittown. She explained that they used to do town hall style meetings previously, but they were not

always productive so they took a hiatus while focusing on other needs assessment activities like the focus groups and Ryan White consumer survey. She informed members that OHP took questions from the healthcare focus groups and developed them to be applicable to the open discussion format. More information can be found at hivphilly.org. N. Johns informed members that the sessions are open to the public, but the purpose is to hear from members of each geographical community. T. Dominique inquired if there were opportunities for virtual participation via conference call or other forms. N. Johns responded that it was a good idea and they should return to it, but those options are not available at this time. She noted that flyers were available and there are Facebook events for members to share with their networks.

April Meeting

N. Johns reminded members of the discussion they had at the previous meeting about changing the committee's April meeting. She inquired if April 25th works for everyone present. The group agreed to the change in date for April.

Motion: D. Gana moved, K. Carter seconded, to change the committee's April meeting from the 18th to the 25th from 2pm to 4pm at the Office of HIV Planning. **Motion passed** by general consensus.

Discussion Items:

Finalize Priority Setting Process

N. Johns reminded members that the 2019 Service Priority Setting Worksheet reflects how members changed the scale percentages and how they weighed the factors such as the Consumer Survey. She reviewed the changes made at the last meeting which are reflected in the handout today. She explained that the scales for the factors were adjusted per the discussions from February's meeting. She noted that the committee didn't finalize the definition and scale for the Community Voices at the last meeting. She noted that decision needs to happen today. D. Gana inquired about the wording for the scale under Community Voices, particularly 1 and 5. He suggested that they should be switched because he feels that "needed" carries greater significance than "important". Members agreed and suggested changing the scale definitions accordingly. N. Johns reviewed the committee's decision to change the definition under 1 in Community Voices to "this service is important to ensure engagement in care and/or viral suppression" and 5 would now read "This service is needed to ensure engagement in care, retention in care and/or viral suppression". The committee agreed that all the Ryan White services are important to engagement, retention, and viral suppression, so the distinction need to be made between 1 and 5.

N. Johns directed the group to the other handouts which refer to the other factors so they could see those other data. She noted that the care continuum handout was now going to be considered for the Community Voices factor, rather than its own separate. T. Dominique inquired if there is any difference between the orange and the blue services on the continuum handout. N. Johns explained that orange are supportive services and blue are core services as defined by the Ryan White legislation. She informed members that she included this in the packet for members to see where the services land on the different

categories of the HIV Care Continuum. She asked the group if there were any suggested changes and there were none noted.

N. Johns directed the group to her presentation. She explained that she was in the process of compiling an explanatory presentation to reduce the number of handouts for the priority setting process. She noted that over the last few months the committee had spent a lot of time and energy deciding which data to use in the priority setting process. This draft presentation was her attempt to collect the relevant data and service definition for each service category to help the committee make decisions under the Community Voices factor. She explained that she would walk through her draft of this presentation with the committee so they could decide what they wanted to keep and change.

N. Johns explained that she pulled together the information on the slides from the various committee discussions. The first data included in the presentation was the EMA's care continuum and service barriers noted in the local CoRCT study that have been shared previously by Dr. Kathleen Brady. She noted that some of the service barriers are specific to services and some are more general barriers. Following these data are some key epidemiological data points to help them think about vulnerable populations and emerging trends.

The next part of the presentation walked through each RW service category. N. Johns explained that each service category would have the HRSA definition (edited for usability) on the left side and epidemiological data, consumer survey data, and other relevant data on the right-hand side of the slide. The service definition includes what can be paid for as well as the key components of the service that must be provided under the RW program. N. Johns reviewed a few slides with the group to share what types of the information.

A. Thompson inquired if the Ryan White system definition is required for members to make a decision because he thinks the HRSA side is more so for the providers to understand what they are supposed to do under each category. He suggested simplifying the language of the definitions to the key points for their purposes of decision-making. He suggested that the committee doesn't need to have the official definition to make good decisions. D. Gana agreed that it is too much information for their purposes. G. Keys agreed and keeping the process and information simplified will allow for more consumer and community participation. N. Johns understood members concerns but she suggested that there are services that may cover things that people aren't aware of, but offered she could highlight those points in another way. She suggested that they could highlight the key sentence or two for a definition. A. Thompson suggested that they could have handouts with the detailed definitions for members to look over if they want to. N. Johns suggested that she can include the page reference to direct members to more detailed information in the allocations packets. J. Jackson agreed that keeping things simple will add people's understanding and willingness to participate. N. Johns acknowledged the tension between providing adequate information for decision-making and overwhelming participants with too much data. A. Thompson encouraged the inclusion of ideas and information that might not be obvious to participants but important in the context of

priority setting, like the ability for syringe access programs to be covered under Ryan White.

N. Johns explained to members that she thought they could watch through each service category as they are doing Community Voices together whenever the committee went through the priority setting process. She would review the information on the slides, participants could share any relevant information or ideas, ask questions, and then the group could vote for the Community Voices factor for one service at a time. The advantage of taking the time to walk through the services one at a time is that everyone is looking at the same information and it is easier to make sure everyone is following and participating. The group agreed with that process. She explained that the information on the slides are meant to be the framework for the conversation and these is time and space for including other information. She acknowledged that some service categories have less information to include and that she will have to use her judgement and creativity to make sure all services are given the same consideration.

N. Johns walked through a few service categories with the group, including substance use treatment services and early intervention services. She noted the concurrent HIV/AIDS diagnoses data is one way to think about who we are and are not testing. K. Carter inquired if OHP knows which specific counties are experiencing concurrent diagnoses of HIV/AIDS. N. Johns stated that she can get the information and that this would be more of an allocations/directives to AACO discussion because the priority setting is for the whole EMA and not about specific regions or categories. She noted that it might be about where Early Intervention Services are needed in specific regions and counties. The priority setting process helps bring these kinds of conversations about needs to light, that can then forward to allocations meetings. N. Johns asked the group if the general process sounds good to them. D. Gana asked if there could be hard copies of the allocations materials (unmet need data, HRSA definitions, etc.) available during priority setting. Group agreed to the process.

N. Johns asked the group how they would like to vote during priority setting and the scales, weights and definitions of the priority setting process. The group also needs to decide on what date to do the priority setting.

G. Keys stated that she thought voting with the use of numbered card was easy the last time. Members agreed. N. Johns informed that M. Ross-Russell most likely will use a spreadsheet tabulate the totals for each service. The group can use the cards to vote individually and the votes can be entered into the spreadsheet and the tally will happen via the computer. She said that it will happen during the meeting, but the results may not be instantaneous. A. Thompson noted that it was pretty quick last time to get the results in real time. N. Johns noted that if the number votes changes throughout the meeting, then that can delay something. T. Dominique inquired when people who applied for HIPC membership get their appointment letters. N. Johns responded that it is entirely up to the Mayor's Office to get the official letters out to members, but they have not been sent to the Mayor quite yet. T. Dominique was concerned with not having any members to vote on priority setting. N. Johns noted that the committee makes up their own rules around

voting and this committee has operated under the rule that everyone present in the meeting can vote on motions and help make decisions. Not matter what the committee decides around priority setting, the Planning Council must approve it before it can be considered an official decision of the HIPC. T. Dominique asked that a general announcement be made to the HIPC and community members once the date for priority setting is set.

The group discussed the need to have an alternate member chair the April 25th meeting because A. Thompson would not be in attendance. The group decided that as needed, the members will volunteer to co-chair meetings.

A.Thompson said that he had called different EMA's to see what kinds of processes and data they used. He noted that the other states and EMA's he spoke to were impressed that this EMA uses data. He said most others use subjective processes. N. Johns noted that this current process was influenced by and based on the New York EMA's process.

J. Browne noted that the scale for the Consumer Survey factor was not reflective of the percentages. N. Johns noted that it was an error from copying over the former scales. She explained that it would be changed to have the 8 score tracked to the highest percentage in that data and 1 would be "no mention" like the other factors, with other percentages equally divided between 3 and 5.

A. Thompson suggested removing "opinion" and adding "experience" for Community voices. N. Johns noted that change would be made. A. Thompson inquired what members thought about the scales, percentages, and definitions. Members had no concerns.

The committee discussed the questions that are included in the Medical Monitoring Project and the different service categories that are not captured currently. T. Dominique suggested that the committee can ask the local MMP project to include those questions in the future. N. Johns noted that not all the services noted in the Unmet Need data are not aligned with Ryan White service categories, Benefits Assistance is a good example. In some years it has been assigned to Legal services other Non-Medical Case Management. This is where the community expertise comes into play to determine how to use the data effectively. N. Johns noted that the data will be reported on the table accordingly to how they are reported in Client Services Unit or Medical Monitoring Project.

The group discussed that Medical Case Management isn't included in the CSU data because it is assumed that people calling the intake line are in need of case management because that is how it accessed. A. Thompson noted that CSU Intake data is the largest data set we use. N. Johns noted that in the previous priority setting process Medical Case Management was assigned a score of 8 because it is understood that it is a high need for PLWH in the EMA. T. Dominique asked if patient navigation and case management an automatic 8 since they know many people calling in need these things under the CSU Intake data. A. Thompson noted that patient navigation is probably an even higher need than MCM for people calling the line, because people may not need MCM but they do need HIV care and help accessing the system. K. Carter noted that the people calling in

the intake line are the types of people who need patient navigation, people who are newly diagnosed and people returning to the system. A. Thompson noted that the data show that people who have case management have better outcomes than people who do not.

G. Keys inquired if people are calling for information about HIV medical care. J. Browne noted that people call the information line to access medical care and people who are going through intake for Medical Case Management, there are two different data sets that are available. She noted that she could share that data as well.

The group discussed that different providers may not go through Central Intake for MCM. A. Thompson noted that he didn't think the New Jersey providers go through that process. This would mean that there is a gap in the data for South Jersey. A. Thompson explained that as far as he knows that the New Jersey providers are taking new clients into MCM without going through central intake. J. Browne commented that she wasn't sure of the official answer but she could find out who is included in the data set. N. Johns noted that using data that excludes a region of the EMA may make people feel excluded from the process. The committee discussed the various HIV providers in the 4 New Jersey counties. They estimated it could be a few thousand RW clients. The committee agreed to wait to have the answer from CSU about who is included in the data set before moving forward with priority setting.

J. Browne asked if there was a way to separate the NJ consumer survey respondents and then weight that heavier. N. Johns explained that is easily done. A. Thompson noted that the limitation to that solution is that the consumer survey data speaks to people who are engaged in the system. He said that he would like to speak with the NJ Planning Council members before coming to a decision. He noted the difference between the consumer survey data numbers and the CSU Intake numbers – the needs are so different. He noted that the consumer survey data is "I needed and I couldn't get" a service and the CSU data is "I need this service". N. Johns explained that the consumer survey also asked if people used a service in the last 12 months. She noted that there is a reasonable doubt about the "I used this service" answer because of discrepancies in survey answers. N. Johns noted that the CSU sample is big and there is a question whether things are really that different for people in New Jersey. She explained that the committee has ultimate discretion on the priority list, so there is room for adjusting the list based on community input and all the data as a whole.

The committee discussed that the data sets are not EMA-wide. Medical Monitoring Project is Philadelphia only. A. Thompson noted that there is a New Jersey MMP data set but it is not reflected here.

The committee discussed the timing of doing the priority setting process. N. Johns explained that there isn't a sense of urgency, but it would be good to do the process before the allocations process in July. She explained that it would also be good for the Planning Council to discuss the process and the limitations of the data. The committee decided that the process would be at the May Comprehensive Planning committee

meeting, in order to give time for finding out the answers and give the Planning Council a chance to weigh in.

N. Johns reviewed the next steps:

- Check in with CSU to see if New Jersey is included
- Priority Setting process at the May committee meeting
- Bring the discussion to the HIPC in April or May

The committee discussed barriers to participation in meetings due to work and other conflicts. A. Thompson noted that his continued conflicts are why he is going to step down from the council and co-chair position.

T. Dominique said that she would ask to find out how to get the suburban MMP data sets for use for the Planning Council. The committee discussed their experiences with the Medical Monitoring Project and how it is conducted. T. Dominique noted that the whole data set is reported out in aggregate, not just provider sites. A. Thompson asked if the provider sites could be separated out from the aggregate set.

Old Business:

Racial Equity Workgroup

N. Johns explained that there were no volunteers to be a member of the workgroup or expressed interest in participating. A. Thompson asked if there could be someone brought in to help the HIPC with the process because there are so many ways to go with this kind of work. N. Johns suggested the Planning Council could begin the work to look at its internal processes and membership for equity and inclusion. She agreed that there is a lot of levels. She suggested the committee bring this to the Executive Committee to explore where this fits the HIPC's work/calendar. A. Thompson suggested having a facilitator to come to Executive Committee to help with that discussion. K. Carter noted that Positive Committee began some work looking at inclusion and equity for PLWH in the HIPC's work and membership. A. Thompson noted that an expert could provide questions and avenues of inquiry for the HIPC. He noted that membership is the beginning step to look at equity. N. Johns noted that the discussion will be brought to the Executive Committee and OHP can investigate possible facilitators.

Co-Chair Nominations

The group noted that no one present was able to accept a nomination. N. Johns noted that it is possible for people to chair more than one committee, but it is not encouraged. She explained that bringing this opportunity to the Planning Council for people who might be interested in stepping in leadership. She explained that there is OHP support and mentorship opportunities for people who are interested. A. Thompson asked the group to talk to other members and encourage people to check out the committee. He noted that the equity conversation might be a way to get new leadership in the committee, because it is not as technical as the conversations about data and priority setting. The committee discussed how they can share co-chair duties until they settle on an official leadership. The committee discussed how the membership is limited by the fact that HIPC meetings

are during the day. A. Thompson noted that other EMA's have their meetings in the evenings. N. Johns said that this conversation is a perennial one. A. Thompson commented that this should be a part of equity discussions. N. Johns encouraged the committee to bring their concerns to the Executive Committee and the full council for conversation. The committee discussed that having calling in options doesn't really address inclusion and equity challenges. N. Johns noted that the OHP will be open and available for whenever the community decides the meeting time.

New Business:
None.

Announcements:
D. Gana announced the CFAR Red Ribbon Award nominations are open until July. Electronic submission of letter of recommendation and resume of the nominee.

Adjournment: The meeting was adjourned by general consensus at 4:02p.m.

Respectfully submitted by,

Nicole D. Johns, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- Service Priority Setting Worksheet 2019
- Racial Equity Workgroup Purpose and Scope
- Unmet Need Data
- OHP Calendar

Racial Equity Workgroup Purpose and Scope

Comprehensive Planning Committee January 2019

Membership: Representation from each HIPC committees, AACO, and stakeholders and community leaders from under-represented communities (to be determined by workgroup). Membership of workgroup will be between 10-20 members.

Purpose: To provide key findings and themes to Comprehensive Planning concerning racial equity in the following areas:

- Planning Council Membership/Leadership (current membership, meaningful involvement of most impacted communities, recruitment/retention efforts)
- Provider/Clinic level disparities (workforce, plans for addressing gaps, and resources for supporting equity)
- Funding allocations- particularly Minority AIDS Initiative and Ryan White Part A
- Training & capacity (HIPC and local service providers)
- Racial subpopulations disparities in health outcomes and service access

The workgroup will be provided with data from OHP and AACO to make assessments on the above areas of focus. These quantitative and qualitative data sources may include RW program data, HIV surveillance data, allocations/spending data, utilization data, needs assessment data, other local or national research/data, HIPC membership information, and other relevant reports.

Workgroup will schedule their first meeting TBD

Workgroup will report themes and trends to Comprehensive Planning. After this report, the Comprehensive Planning Committee will determine how to proceed and whether the workgroup will continue or dissolve.

Comprehensive Planning will include a standing agenda item for the workgroup to provide updates.

Anyone interested in participating should contact Nicole Johns at 215-574-6760 or nicole@hivphilly.org

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 (as informed by EMA data and committee deliberations) and the service category 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. The sample is geographically representative of the EMA and includes PLWH who have engaged in the RW system.	1- no mention 3- >7.5% 5- 7.6-15% 8- 15.1%
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. The data sample if Philadelphia only.	1 – no mention 3 – > 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. The data sample is not EMA-wide- Philadelphia and PA counties with very few NJ.	1 – no mention 3 – >25% 5 – 26-51.6% 8 – 51.7%
Community Voices (40%)	This factor seeks to quantify community experience/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 important to ensure engagement in care, retention in care and/or viral suppression 5- This service is needed 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=1,903)	Medical Monitoring Project (n=166)	EMA Consumer Survey (n=392)
Medical Care	32.8	4.2	3.8
Medications	23.1	1.5	3.8
Treatment Adherence	45.5	1.9	9.9
Dental	3.4	45.1	11.2
Home Health Care	1.8	N/A	11.2
Mental Health	18.5	9.7	10.5
Case Management	N/A	15.7	5.9
Substance Abuse Treatment	5.6	2.7	8.7
Food	18.9	6.5	9.9
Housing	51.7	16.0	15.1
Transportation	25.4	12.5	11.2
Support Groups/Peer Support	5.6	8.0	9.4
HIV Education/Risk Reduction	9.2	N/A	N/A
Benefits Assistance	32.5	18.4	N/A
Health Insurance/financial support	18.9	N/A	12
Language Translation	3.1	0.0	10.5
Patient Navigation/Care Outreach	N/A	2.3	7.9
Nutritional Counseling	1.1	N/A	10
Legal Services	3.6	N/A	13
Emergency Financial Assistance	11.2	N/A	18
Assistance with household tasks	N/A	N/A	12
Home Health Care	1.7	N/A	11
Rehabilitation (physical)	N/A	N/A	11
Hospice	0	N/A	11
Respite Care/Adult Care	N/A	N/A	11
Child care	N/A	N/A	10