
**Comprehensive Planning Committee
Meeting Minutes of**

Thursday, October 17th, 2024

2:00 p.m. – 4:00 p.m.

Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Debra D’Alessandro (Co-Chair), Gus Grannan (Co-Chair), Nafisah Houston, Pamela Gorman, Gerry Keys, Lupe Diaz

Guest: Carolyn Ream, Jessica Browne (DHH), Laura Silverman (DHH), Blake Rowley (Gilead)

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

Call to Order: D. D’Alessandro called the meeting to order at 2:06 p.m.

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

Approval of Agenda:

D. D’Alessandro referred to the October 2024 Comprehensive Planning Committee agenda and asked for a motion to approve. S. Moletteri said the agenda should be amended to replace Modalities of Prevention & Care with the CPC Recruitment Presentation. The presenter had a scheduling conflict and would be unable to attend. **Motion: L. Diaz motioned; D. D’Alessandro seconded to approve the amended October 2024 Comprehensive Planning Committee agenda via Zoom. Motion passed: 4 in favor, 1 abstained.** The amended October 2024 Comprehensive Planning Committee agenda was approved.

Approval of Minutes (September 19th, 2024):

D. D’Alessandro referred to the September 2024 Comprehensive Planning Committee minutes. **Motion: G. Grannan motioned; D. D’Alessandro seconded to approve the September 2024 CPC meeting minutes via Zoom. Motion passed: 3 in favor; 3 abstained.** The September 2024 CPC minutes were approved.

Report of Co-chairs:

None.

Report of Staff:

S. Moletteri reported that the second presenter would not be able to attend the meeting. The committee would instead be working on the CPC Recruitment Presentation. Many members would be reaching their term limit and were required to step away from the HIV Integrated Planning Council (HIPC) for a year. The presentation was to help recruit HIPC members to sit on and chair the CPC in the future. G. Grannan, a co-chair of the CPC, would be reaching his term limit soon.

T. Dominique welcomed M. Ross-Russell back after she was absent due to illness. S. Moletteri announced OHP would be tabling at the Stimulant Symposium at the DoubleTree Hotel and at the AIDS Walk event by the Philadelphia Museum of Art.

Presentation:

-CAREWare-

J. Browne introduced herself as the Manager of Information Services at the Division of HIV Health. She informed the committee that all the data they would see would be exclusively from fake test clients. She began her presentation with an overview of the Ryan White Services Report (RSR). This data report was submitted by subrecipients to HRSA every February. The report contained data elements that were defined by HRSA and were different for each service category. The goal was to have no more than 10% missing data by the time of submission.

J. Browne described CAREWare (CW) as a free HRSA-supported software for managing and monitoring HIV care. CW was programmed and maintained by a company called jProg. All funded Ryan White providers were required to use CW. J. Browne said CW was not centralized and that each service provider had their own version. She listed CW's main functions as follows: managing client records, running custom reports, tracking performance measures, improving quality, and maintaining RSR data.

After explaining what CW was and its purpose, J. Browne previewed what CW had looked like and explained how to use it. CW recorded clients' information such as name, gender, sex at birth, date of birth, zip code, race/ethnicity, HIV risk factors, vital status, enrollment status, Ryan White eligibility, and HIV Status. J. Browne explained that these fields were required because the information contributed to the RSR or performance measures. One of the most frequently asked questions was about the gender options in CW. CW allowed a provider to input Male, Female, Transgender, Female to Male Transgender, Male to Female Transgender, other, and Unknown. The options were defined by HRSA and could not be changed or edited by an individual user. As asked in previous HIPC meetings, J. Browne mentioned the concern that CW was unable to track history of incarceration. This meant that a CW user could be logged as incarcerated in the client's enrollment status, but once the client was no longer incarcerated, their new enrollment status would overwrite their incarcerated status. CW was unable to track a client's previous incarceration history. Next, J. Browne explained how HRSA guidance directed providers to enter their own service location as the zip code if the client was without housing or unstably housed.

T. Dominique asked if it was possible for two providers to enter different information on a client. For example, a provider may enter into CW that a client was incarcerated while another provider marked the client as not incarcerated. This discrepancy could potentially track incarceration history. J. Browne replied that since CW was not centralized it was possible. In order to track clients, DHH used an encrypted ID, so they would be able to see a client's history when initially viewing data. However, this would be corrected and any not-up-to-date data would essentially disappear.

J. Browne looked at the different options for enrollment status: active, inactive/case closed, incarcerated, referred or discharged, relocated, and removed. If a client was incarcerated, a provider would switch enrollment status to “incarcerated” since the client was no longer with their program. If a client returned to their program post-incarceration, they would change the enrollment status back to active. D. D’Alessandro assumed there was an exception for programs that provide case management and care to those who are actively incarcerated. J. Browne was not entirely sure but felt these programs selected “active” as the enrollment status and had other internal systems for tracking incarceration status.

J. Browne presented the committee with an example of what the services section in CW would look like. She stated that subrecipients were required to enter the date, contract name, service category, service name and number of units when they were recording data on services. Service units were defined differently for each service category. For example, some service units were measured in time while others were measured in number of client visits. Services were allowed to record whether a visit was a telehealth visit or an in-person visit. However, at that point, only O/AHS was required to track whether the visit was telehealth or not. Tracking these fields allowed DHH to gather data for their performance measures and reports to HIPC and other bodies.

In the annual review, providers were required to enter annual review data for one of the following in CW: housing, health insurance, poverty level, substance use, and mental health. The only category that providers were all required to enter data into was housing services. All core services had to enter data for health insurance. These fields were required for RSR reporting and Substance Use and Mental Health impact O/AHS performance measures. It was commonly asked if DHH knew of a client’s substance use history or mental health diagnosis through the CW data. However, this was not how they knew. She said answering “yes” or “no” only referred to whether a client was screened for mental health/substances and not whether they had a history.

J. Browne described the fields that O/AHS were required to enter in their Lab and Screening Lab Data. They had to enter information for Viral Load, CD4, Hepatitis C, Gonorrhea, Chlamydia, Syphilis, Hepatitis B, and TB. They were also required to enter the following screenings in CW: Pap Smear, Colposcopy, Hysterectomy, Point-of-care and iART follow up. Medical Case Managers were required to enter information for screenings such as MCM Tier (comprehensive or standard) and the Service Care Plan Creation/Update.

In addition to everything J. Browne had previously mentioned, MCM providers were required to enter case notes (DAP notes) and data on medications into CW. O/AHS providers were also required to enter data on immunizations (HEP A/B) and medications (ART and PCP Prophylaxis). S. Moletteri asked if DHH ever used case notes in their data analysis. J. Browne replied that they did not use the case notes for data analysis. The only time they reviewed case notes was when the Program Services Unit conducted provider site visits.

J. Browne reminded the committee that CAREWare was not centralized. Providers using CW do not see any changes other providers make. DHH did not have direct access to subrecipients’ CW

data. When DHH requested information from a provider, they must run a report on CW and submit the information to DHH through a secure channel on a secure File Transfer Protocol (FTP) site.

J. Browne described the different types of data reports they collected. The Finance Report represented the number of clients and units. This was collected quarterly. The Performance Measure Report collected data on O/AHS and MCM. DHH created a provider-level feedback report which showed subrecipients how their performance compared to their previous year. DHH also sent out a bimonthly aggregate report which showed the outcomes for each service across all the providers. The Provider Data Export was the export of all the CW data. DHH combined this data into one database and collected it quarterly.

The Women, Infants, and Children (WIC) Report was a breakdown of contracts by gender and age submitted to HRSA. The RSR Report collected the required data elements for RSR to assess if providers were making progress towards reducing their missing data. The report was created and submitted three times per year. If a provider was missing information from their data entry, they would be asked to resubmit their information with the corrections.

J. Browne explained that DHH was very conscious about collecting data and only collected data that they needed or had used for. Some of the uses of the data were quality assurance, outcome reporting, fulfilling data requests, and clinical quality improvement.

Discussion Item:

-Committee Presentation-

At the last HIPC meeting, the Nominations Committee suggested that each committee create a presentation to recruit members to the subcommittees from the full council. The subcommittees were to create a presentation stating their responsibilities and goals. At a future HIPC meeting, each subcommittee would be given approximately five minutes to recruit new and existing HIPC members.

The subcommittee looked at the draft slides that S. Moletteri pulled up. K. Carter suggested that they add the meeting time to the first slide. The committee agreed to add that they met on the third Thursday of every month. On the “Meet Your Committee Members” slide, S. Moletteri added the names of the co-chairs. K. Carter suggested inserting the staff member assigned to the committee on this slide. S. Moletteri asked if they had wanted more than one speaker for their presentation. G. Grannan replied that they did not want to have too many speakers. The committee decided that they would revisit this topic on a different date once they had more of a final draft of their presentation.

T. Dominique asked if the co-chairs and other committee members would consent to adding their picture or be listed in the presentation to make it more personable. She explained that if a person saw a particular HIPC member they knew in the subcommittee, they might be more interested in joining that subcommittee. G. Grannan’s and D. D’Alessandro’s names were added to the presentation as the co-chairs. K. Carter and P. Gorman volunteered to add their names and

pictures to the presentation. S. Moletteri said if there were any other members who were interested in adding their names to the presentation, they could reach out to them after the meeting.

For the goals and responsibilities section of their presentation, S. Moletteri read descriptions of the CPC from the OHP website and the HIPC ByLaws. They asked if and/or which parts of the language could be incorporated into the presentation. P. Gorman suggested condensing the description on the OHP website. She said their goals were to make recommendations relevant to the Integrated HIV Prevention and Care Plan, priority setting, and other activities assigned by HIPC. G. Grannan suggested they add that the CPC also reconciled the long-term goals of the RW Plan and data from epidemiological reports and research. K. Carter said they had also assessed documented need for priority setting and ensured HIPC was well informed for allocations.

The committee would list the activities and responsibilities they had done to achieve their goals. The committee listed their work related to the priority setting process, Integrated Plan, Consumer Survey, epidemiological infographics, End the Epidemic (EHE) process, service standards review, and fulfilling data requests.

The next portion of the presentation answered the question of why a person would join the CPC and the benefits it presented both individually and for the community as a whole. On a personal level, the committee listed the following: (1) gaining familiarity with plan & epidemiological data to see how they influence each other, (2) seeing how programs are implemented and measured through DHH's reporting, (3) understanding what is going on and the behind the scenes of HIPC meetings since many topics come through CPC first, and (4) more room to exercise and grow your personal expertise.

As for community benefits, the committee listed the following: (1) CPC provided diverse voices for community, (2) the committee ensures programs are responsive to the community as represented by CPC members, (3) the committee is more focused on accomplishing tasks instead of observing formalities and allowed more room for expressing concerns and ideas than the full council, and (4) it presented a good opportunity to expose individuals to how community planning works and involve them in that process, both city and federal.

T. Dominique suggested that the committee work on brainstorming unique benefits, since much of what they had come up with could be applied to the other subcommittees as well. The committee suggested the following benefits unique to CPC: (1) CPC often decides what the whole HIPC focuses on/their direction and vice versa – HIPC gives “hot topics” to CPC to delve into, (2) CPC work filters in to every other committee, (3) CPC offers a unique perspective through involvement with data to uncover community needs, and (4) the committee helps the full council assess gaps in care to reach those better health outcomes, which is the ultimate goal of council work.

S. Moletteri said they could add a slide in the future to describe how CPC's work had benefited HIPC as a whole.

K. Carter asked if they could add their resource page to the chat during the presentation. M. Ross-Russell said it would be helpful to have a list and links to all the work that the CPC had accomplished. S. Moletteri agreed that this would be useful, suggesting they add several links to the presentations so people could go forth and explore more on their own. They suggested combining the links together in one document for easier accessibility. S. Moletteri said they would email the document after the meeting after they gathered the links.

The last slide had K. Trinh's email address listed as the staff member to contact if a member was interested in joining the CPC. S. Moletteri said they would be creating a survey to send HIPC members at the end of each presentation to gauge interest in the committee.

Other Business:

None.

Announcements:

None.

Adjournment:

G. Grannan called for a motion to adjourn. **Motion: L. Diaz motioned, K. Carter seconded to adjourn the October 2024 Comprehensive Planning Committee meeting. Motion passed: Meeting adjourned at 3:50 p.m.**

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2024 CPC Meeting Agenda
- September 2024 CPC Meeting Minutes