HIV Integrated Planning Council
Meeting Minutes of
Thursday, April 11, 2019
2:00 p.m. – 4:00 pm.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Katelyn Baron, Henry Bennett, Michael Cappuccilli, Keith Carter, Mark Coleman, Evette Colon-Street, Maisaloon Dias, Lupe Diaz, Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, Sharee Heaven, Peter Houle, Richard LaBoy, Brian Langley, Dena Lewis-Salley, Lorett Matus, Nicole Miller, Joseph Roderick, Samuel Romero, Eran Sargent, Clint Steib

Excused: Janice Horan, Gerry Keys, Christine Quimby, Erica Rand, Coleman Terrell (AACO), Gloria Taylor, Gail Thomas

Absent: La'Seana Jones, George Matthews, Jeanette Murdock, Nhakia Outland, Dorothy McBride-Wesley, Terry Smith-Flores, Adam Thompson, Lorrita Wellington, Jacquelyn Whitfield, Zora Wesley, Melvin White, Steven Zick

Guests: Chris Chu (AACO), Ameenah McCann-Woods (AACO), Nicole Reiser, Kim Wentzel, Luis Noquena, Blake Rowley

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan

Call to Order
L. Diaz called the meeting order at 2:06pm

Welcome and Introductions
All present introduced themselves. New members were welcomed.

Approval of Agenda
L. Diaz called for an approval of the agenda. **Motion:** M. Cappuccilli moved, D. Gana seconded to approve the meeting agenda as presented. Motion passed by consensus.

Approval of Minutes (March 14, 2019)
L. Diaz called for an approval of the minutes from the March 14, 2019 meeting. **Motion:** M. Cappuccilli moved, K. Carter seconded to approve the meeting minutes as presented. Motion passed by consensus.

Report of Co-Chairs
L. Diaz reported that she attended the Listening Session in Media the previous night and noted that there was a fruitful discussion. She reported that the Urban Coalition of HIV/AIDS Prevention Service Providers (UCHAPS) is meeting July 1 and 2 in either D.C. or Baltimore. They will meet for two days to discuss the federal Ending the Epidemic initiative and the future of UCHAPS. UCHAPS is a coalition of 6 major cities which discusses what cities are doing for HIV prevention, mostly through virtual meetings. She noted UCHAPS also provides technical

assistance. K. Baron reported that UCHAPS did a survey of jurisdictions for technical assistance (receiving and giving) in March. S. Heaven reported that HOPWA allocation for Philadelphia has not been received yet, but hopefully by the next HIPC meeting. S. Heaven asked people to introduce themselves when they speak to help new members learn names.

Report of Staff
M. Ross Russell reported that the first listening session at Media Library occurred the previous evening. She thanked L. Diaz and A. Edelstein for attending and extended extra thanks to K. Carter for being a great host. She noted the next listening session would be in Levittown on April 30th. She asked members to help get the word out to organizations and individuals. R. Laboy asked what the listening sessions were. M. Ross-Russell explained that OHP was going out to the counties in the EMA to learn about barriers and experiences with HIV medical care. The purpose is to reach people who have not been able to participate in other ways. M. Cappuccilli asked if they were formal or informal discussions. B. Morgan explained that they are structured and facilitated, although not recorded except through notes on large newsprint. She explained that OHP staff ask questions about recent experiences with medical care and successes and challenges receiving needed services.

M. Ross-Russell reminded the group that she would be coming back to review the roles and responsibilities of the HIPC, AACO, and CEO (Mayor of Philadelphia). She pointed the group to the handouts to the matrix of responsibilities. She instructed the group that they will fill out the matrix according to the information provided at the last meeting. She reviewed the matrix with the group. She explained the headings of the columns: HIPC= Planning Council, CEO= mayor, recipient is AACO. M. Ross Russell led the group through the questions one by one and shared the answers *(see handout for more information)*. She distributed a handout with the matrix with correct answers.

Public Comment
No comments.

Presentation:
Understanding Data
B. Morgan told the group that they will have a quiz during this presentation too. She introduced herself as the person who works a lot with data and the epidemiological profile. This presentation will look at some data from the epidemiological profile and other data the HIPC uses to make decisions. She said that this presentation will be interactive. She pointed people to the worksheet about data terms and concepts to work solo or with a partner for the next several minutes. The group worked on the handout in small groups/pairs.

B. Morgan explained she would go through the answers and then have discussion[1].

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[1] Answers: 1. quantitative data 2. geographic disparities 3. resource inventory 4. Prevalence 5. Population 6. Incidence 7. needs assessment 8. epidemiological profile 9. Utilization data 10. Subpopulation 11. qualitative data 12. estimate of unmet need

B. Morgan reviewed the definitions of population, subpopulation, and data (see presentation slides for details). She explained that "prevalence" is often referred to the number of people living with HIV in the EMA. Whereas, "incidence" is the number of new HIV cases. She further explained that the number of new cases is not known, the surveillance information only has the information about the people who have tested positive, not everyone who has acquired HIV. She noted that the EMA has an extremely educated guess through a math model, and for this reason the HIPC usually talks about new HIV diagnoses. She shared that there were 721 new diagnoses in 2017. B. Morgan explained that "incidence" is everyone who acquires HIV in a year, but sometimes it takes a while for people to get tested. New diagnoses are counted, because surveillance knows that they have a positive test. She defined 'public health surveillance' as the systemic collection, analysis and interpretation of data essential to public health services. She noted that she used the HIV surveillance data that Dr. Brady often shares with the HIPC. She explained that prevalence, Incidence and new diagnoses are all surveillance data.

B. Morgan defined "geographic disparities" as the differences in access to appropriate services based on where an individual lives. This data can be displayed in tables or maps. B. Morgan noted that M. Ross Russell makes maps for each of the EMA's counties by socio economic, health and other data. She noted that qualitative data is related to qualities, it is usually a narrative from focus groups, interviews, listening sessions, etc.

She reviewed the definition of needs assessments and shared examples like focus groups, town halls, surveys, etc. B. Morgan noted that the Epidemiologic profile included data from many sources like surveillance, needs assessments, census data and other state and local sources. She explained that the group would be working with epidemiological data together in a few minutes.

B. Morgan suggested that often people read tables and charts as quickly as possible for the information they want to find. She shared the national HIV care continuum. She instructed the group to look at the table and chart and ask themselves these questions: where did the data come from, where did you find it, what do I know about the source, what does the title tell us.

She reviewed the table example with the group. She explained this came from the CDC's website. She asked what does that tell us. K. Carter said it is data from across the country. E. Colon-Street said that the data is reliable. B. Morgan noted that the CDC gets information from state and local health department. B. Morgan explained that she reads the table from outside in and suggested the group look at what's being counted, how it is counted and what's being left out. She pointed the group to look at the axis of the graph. She asked what was being counted. The group said people. B. Morgan said that it was the percentage of all people living with HIV. She explained that the all people living with HIV is an educated guess. Whereas people who are diagnosed is a real number. She asked how would we know how was receiving care. E. Colon-Street replied that the states report diagnoses to the CDC. B. Morgan said that RW clinics only count RW clients. How do we know who is receiving care? She explained that jurisdictions are able to count doctor's visits through CD4 and viral load reporting, but noted that's a specific kind of care. She further explained that "retained in care" is measured the same way. She noted that "virally suppressed" was known through viral load reporting.

B. Morgan explained that lab reporting varies by the state. She reported that PA doesn't have mandatory lab reporting for people with CD4 count over 200, so it can't be known if those people are in care according to this measure. She further explained that NJ also doesn't have complete viral load and CD4 counts, so PA and NJ are not accurately captured in these data, only through mathematical models. B. Morgan reviewed the graph. She asked what the story does it tell us? D. Lewis-Salley replied that the data only tells us part of the story. E. Colon-Street noted that there are a lot of people are not virally suppressed. L. Diaz observed that the 85% are diagnosed. She said she also seen 100% in care continuums. B. Morgan explained that there are two kinds of continuums, so the starting line is different between prevalence and incidence estimates. She explained that data is not objective and how it is presented is biased. This is true of all data. K. Baron asked about retained in care and how it can be less than virally suppressed. S. Romero said that retained in care reflects tests in lab results in a particular time period. He further explained that viral suppression is just the lab results, without the timeframe. Retained in care is measured that having CD4 and viral load at least three months apart in the same calendar year. Virally suppressed numbers include people who are undetectable but they do not meet retained in care measure because they only visit the doctor once a year.

 K. Carter noted that the RW data looks different than this continuum. B. Morgan explained that the RW client data looks very different. RW clients have much better outcomes than all people living with HIV. D. Lewis-Salley offered that there are people who have a RW certification card but don't use services so they are not counted. A. McCann-Woods explained that the RW card just signifies that the person is eligible for services under the RW umbrella but they may or may not be utilizing RW services. M. Ross-Russell explained that there are 26,000+ people living with HIV in the EMA and on average 14,000-16,000 people use RW services in a year. She noted that means there are 10,000 PLWH who do not use the services. She further explained that CD4 and viral load counts from surveillance include all PLWH regardless of whether they are RW clients or not. The health departments have strict reporting requirements for laboratory results. B. Morgan explained that this is why you need to think about who is and isn't included in the data. P Gorman said that people with RW cards got them through RW service providers. Those people are counted somehow because they have the RW card.

B. Morgan explained that this exercise is for partners. It is from the section of the epidemiological profile about people who are at risk for HIV. She said that the text explains what the Behavioral Risk Factor Surveillance System is and how it works and on the back is an example of that data on the other side. B. Morgan shared a worksheet with the group and asked the group to take several minutes to answer the questions with their partners. The group worked on the exercise.

B. Morgan asked the group what does the handout tell about the source. C. Steib said that the limitation of the data source was self-reported data. It was a phone survey and people without phones weren't counted. He also noted that it's only in English. B. Morgan explained that "self-reported" means it is what people say. B. Morgan also noted that there are only two genders: male and female and it is not clear how they determined a respondent's gender. K. Carter observed that there are no racial/ethnic breakdowns. M. Cappuccilli noted that the survey isn't anonymous because they are calling people on the phone. A. Edelstein noted that the data is not broken down by geography. B. Morgan explained that sometimes limitations are around how the

survey was done or who answers. She noted there are a lot of people who will not answer the phone from an unknown number. She observed the sample skews older than the general population, probably due to the methodology. She observed that some flaws don't mean it isn't useful. M. Coleman noted that some people may not be able to take the survey in English. J. Diaz stated that he would like to know how many phone calls were attempted and then how many were answered. B. Morgan noted that we do not know if they made repeated attempts to make contact.

B. Morgan asked what was being counted. C. Steib noted it was people who said they were tested for HIV. B. Morgan said that it could include people who think they were tested because of some other unrelated bloodwork. She noted that the BRFSS includes the exact question that was asked, which helps us understand more about the data. She asked what wasn't being counted. C. Steib noted adolescents are not included in the data. E. Colon-Street noted that non-English speakers are excluded. B. Morgan noted that people without phones are also left out. M. Coleman noted that homeless population is likely not counted. E. Colon-Street noted that people who do not have insurance might not be counted. B. Morgan said that it shows that routine testing isn't really happening, as seen in the data with the older people. L. Diaz said that the number of people who are tested goes up after age 25.

B. Morgan asked if there was anything surprising in the data. M. Cappuccilli said it was balanced between male and female. He noted that he would have thought it would have been higher for females because they are more likely to access medical care.

B. Morgan asked what new questions do people have after working through the exercise. E. Colon-Street said this shows how important incentives might be in testing. M. Coleman noted that Salem County is not included in the sample. B. Morgan said that the sample is not very big for the whole EMA. M. Ross Russell said that Salem is included in the Wilmington Metropolitan Statistical Area. She noted this is often true for federal data and Salem is not able to be separated out from those data sets.

B. Morgan explained that during allocations the HIPC use a lot of data and charts. She explained that in a few minutes the group would have presentations on specific service categories and there are handouts in the packets. She directed people to the Ambulatory Care handout and the table on service utilization. She asked the group to share whatever they see is interesting or questions they might have. E. Colon-Street said that she thought the medical units would be lower now that so many more people are covered under health insurance. She explained that NJ Part B doesn't fund Ambulatory Care. K. Carter said that the EMA is doing better than national averages in the care continuum. A. McCann-Wood explained the 2015 to 2017 the number of units are going down, projections are rising. M. Ross-Russell explained that it is based on historical data through a statistical algorithm with data from 2001 to present. B. Morgan said that projections are based on the history of use of service and not based on policy changes, funding shifts, etc. M. Cappuccilli said that intuitively you would think the changes in the recent years would make the projections lower. M. Ross Russell said that it is a relic of history. Originally people went to the doctor more often than they do now and that effect is here in the projections. M. Cappuccilli asked the difference Medical Care Dollars is the actual expenditure rather than what was allocated. Allocated is what was budgeted for by the HIPC.

Discussion Item:
Allocations Preparations
M. Ross-Russell explained that at the last HIPC meeting members were asked to volunteer to review the service category sheets from the allocations packets. She informed the group that Gerry Keys was unable to attend this meeting so M. Ross Russell will present on Ambulatory Outpatient Care. She explained that the Health Resources and Services Administration (HRSA) definition is the official definition from the federal government. This is how the services are supposed to be provided. This is the expectation for service delivery. M. Ross Russell explained that she gets the data from spending and units from the recipient every year to include in this table. The cost in the data is the number of people served divided by the actual spending. It is not how much the service per individual costs but how much we are paying. She went on to explain that RW is funder of last resort, every other source of funding should be used before RW funds are used for uninsured, underinsured or uninsurable. She shared that she uses the most recent available information for the Funding By Part and Other Payers table. The purpose of this table is to inform HIPC on other funders for the services. She said that last year for allocations Medicare and Medicaid dollars were included in the packet. She then reviewed the data from consumer survey and unmet need data from Medical Monitoring Project and AACO's Client Service Unit Intake data. She explained that AACO also reports considerations and data that can help inform decisions which is the last information included for the service. S. Heaven asked what is the unit. L. Diaz answered that it is a medical visit, other services might be in timed increments like 15 minute units. M. Cappuccilli asked if there is data for NJ counties. M. Ross Russell said that there are data from the consumer survey that could be broken out by region. M. Ross-Russell said this MMP data is Philadelphia only, as presented and the CSU data has limited PA counties and NJ data (because of how medical case management intake is done in those places. Not every provider uses the central intake to bring in new clients.

L. Diaz reviewed the Medical Case Management definition. She explained that medical case management is focused on improving health outcomes. There must be an assessment of client needs around housing, adherence, food, mental health, etc. It also includes an individualized care plan, what is going to be done to help the person improve their health and must be reviewed every 6 months. L. Diaz reviewed from the Recipient considerations that said that studies show that clients enrolled in MCM tend to be adherent to HIV medical care. M. Cappuccilli asked why are the unit costs higher than medical care. M. Ross Russell explained that it is just the division of amount spent by how many clients. More people utilize medical care than MCM. She reminded him that this is how much was paid for the service, it is not the true cost. A. McCann-Woods explained that when providers are awarded the funding, the Recipient has a calculation that notes how many units and clients that should be provided for in each case. She explained that there are more time investment per client in MCM rather than a medical visit, that's something the table won't show you. L. Diaz said it might take two hours to serve a MCM client who needs intense support.

K. Carter explained that he volunteered to review Medical Transportation. He explained that this service is for non-emergency transportation that allow someone access and be retained in core medical services. It can pay for contracted rides. It can also reimburse for mileage for family members and volunteer rides. He further explained that an agency can also purchase a van but it

has to be approved before the purchase. It can pay for volunteer drivers but there are rules around liability insurance, etc. This funding can also cover tokens and other reimbursement. Cash reimbursement and wear and tear of vehicles are not allowable expenses under Ryan White. He noted that there was an increase in clients between 2015 and 2017. He noted that units are just a one-way ride. There was a noticeable increase in units as well. Transportation spending and allocations also increased between 2016 and 2017. He noted that the average cost for client has decreased since 2015. He reviewed the allocations for Part A, Part B, and other RW Parts. K. Carter noted that the consumer survey sample was 392 people and 145 people answered the question about needing transportation- 30% needed and didn't get it. N. Johns noted that this percentage is one of the highest in the survey. K. Carter reviewed the unmet need data and noted the Medical Monitoring Project reported 11.3% respondents need for medical transportation (this is a chart review and interviews). The CSU data is what people identify as need when intake is done by Client Services Unit; it is people entering and re-entering care. A. Edelstein asked why the projections for the future do not note the recent increases in utilization. M. Ross Russell explained that historical data was used in the projection and the service category gets underspending money almost annually. M. Ross Russell noted those numbers are a guess (based only on math) and should be taken with a grain of salt.

M. Ross Russell explained that Direct Emergency Financial Assistance is restrictive, it pays for first and last month's rent, utilities, transportation, medications, food, and back rent. It cannot pay for mortgage, repairs on homes, repairs to cars, or security deposits. She explained that this chart is different because medications and housing were added as subcategories in recent years so there are missing data, it will be added as available. She reviewed that CSU intake data noted that it was needed by 40% of the clients.

Committee Reports
Finance Committee
A. Edelstein explained the committee meets on the first Thursday meets at 2pm. The committee did not meet in April.

Nominations Committee
M. Cappuccilli reported the committee did not meet today because there was orientation for new members. He reminded the group that the social will be after the June HIPC meeting.

Positive Committee
K. Carter reported that the committee met on the previous Monday. He shared that the committee decided to hold a special meeting in June in the evening to allow new people to attend, as a part of an ongoing process of evaluating the committee's processes and procedures to ensure inclusion and meaningful participation of all the EMA's PLWH. He reported that the meeting will be June 18th from 6 to 8pm. K. Carter shared that the committee went over terminology about gender and sex and sexuality at their last meeting. The next meeting will be May 13th from 12 to 2pm. He asked people to let the office know if you will attend.

Comprehensive Planning Committee

N. Johns reported that the committee will not meet in April. She reported that at the March meeting the group discussed priority setting data and process. She also invited HIPC members to nominate themselves or others to be co-chair/s of the committee. That election will happen at the next meeting in May.

Prevention Committee
L. Matus reported that the committee is continuing to review PrEP workgroup report at their next meeting.

Old Business
D. Gana gave a report from AIDS Watch. He shared that no EMA U.S. Representatives are on the House HIV caucus. The PA contingent that visited legislators asked for PA House members to join HIV caucus, and requested additional funds for HIV. He noted that another ask of the action was for comprehensive sexual education.

New Business
None.

Announcements
None.

Adjournment
L. Diaz asked for a motion to adjourn. **Motion:** K. Carter moved, D. Gana seconded to adjourn the meeting at 4:26pm. Adjourned by general consensus.

Respectfully submitted by,

Nicole D. Johns, staff

Handouts distributed at the meeting:
- Meeting agenda
- Meeting minutes for March 14, 2019
- OHP calendar
- Activity 2.4: Review of Roles and Responsibilities Matrix
- Pg. 78-79 of the Philadelphia Integrated Epidemiological Profile
- Understanding Data Worksheet
- Data Terms and Concepts Worksheet
- Excerpts from the Allocations Materials Packet 2018 – Outpatient/Ambulatory Health Services, Medical Case Management, Medical Transportation Services, Emergency Financial Assistance