Ryan White Part A Planning Council (RWPC) of the Philadelphia EMA
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, March 16, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Katelyn Baron, Nicole Miller, Ann Ricksecker, Adam Thompson, Gerry Keys, Nicole Miller, Mark Coleman, Clint Steib, Tre Alexander, Leroy Way

Excused: Peter Houle, Cheryl Dennis, Tessa Fox, Pamela Gorman

Absent: Keith Carter, Karen Coleman, Lupe Diaz, David Gana, Lorrita Wellington, Deanne Wingate

Guests: Sebastian Branca (AACO)

Staff: Mari Ross-Russell, Nicole Johns, Jennifer Hayes

Call to Order/Introductions: A. Thompson called the meeting to order at 2:08p.m. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: M. Coleman moved, T. Alexander seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes *(February 16, 2017)*: A. Thompson presented the minutes for approval. **Motion**: K. Baron moved, T. Alexander seconded to approve the February 16, 2017 minutes. **Motion passed**: All in favor.

Report of Staff: N. Johns stated that paper copies of the consumer survey would be accepted through the end of March. She said that no more had been sent out recently. She said the online survey would be accepted until mid-April. She stated that an average of 4 or 5 surveys were received per week. She asked anyone with completed surveys to send them in.

Report of Chair: A. Thompson stated that the letter to the Pennsylvania Department of Health, Division of HIV Disease had been sent out as approved by the RWPC and signed by Planning Council and Comprehensive Planning Committee co-chairs.

Discussion Items:

- **Review Priority Setting Factors**

N. Johns said that some preliminary responses to question 57 on the consumer survey had been included in today's packets. She said that the answers pertained to client needs and barriers to care. She stated that the packets also included a summary of commonly-mentioned words. A. Ricksecker noted that copays were frequently cited as a barrier. N. Johns added that housing was a barrier, and many respondents were living with family and friends. She noted that she'd also made a chart of responses for question 38, which also concerned service utilization and barriers.

N. Johns told the group that she'd included in the packets a copy of the service priority worksheet from the last time priority setting was done. She reviewed the factors used for the last priority setting process. She noted that data and information that was used to measure these factors was also included in the packet. She stated that there was also a sheet of the previous processes' final priority rankings in the packets.

N. Johns stated that, today, the group would discuss which factors they'd like to change, if any. A. Ricksecker pointed out the grid of responses for question 38 on the consumer survey. She asked if "I needed this service" corresponded to "needed and didn't get." N. Johns replied that it did. She explained that some survey respondents had not seemed to follow the survey directions. However, she stated that the responses were used as entered.

C. Fields noted that some people did not understand the survey questions. She pointed out that literacy could be an obstacle to completing the survey. She said she had been told by a provider that she'd be denied services if she didn't fill out the survey. She stated that she'd asked for assistance in filling out the survey and hadn't received it. A. Thompson suggested that she share information with OHP staff about which provider had made these claims. He said his organization had assisted clients to fill out the survey. He stated that OHP staff would follow up with any providers who were not following instructions. K. Baron stated that Ryan White funding did not depend on whether or not clients filled out surveys.

A. Thompson reminded the group that they'd discuss the participation of expert stakeholders in the priority setting process. He reviewed the factors from the last time priority setting was done: 25% Consumer Survey, 30% Gardner Cascade/Care Continuum, 30% Unmet Need, and 15% Essential Health Benefit. He asked if anyone had feedback on the factors.

A. Ricksecker stated that the essential health benefits may change in the future due to coming changes in healthcare legislation. She stated that the essential health benefit factor had been included to gauge whether or not a service would be covered by other funding sources. She said that a factor specifying "other payers" was not permitted, so the essential health benefit factor measured something similar. She noted that service categories only covered by Ryan White were vulnerable in the event of cuts.

M. Coleman asked how future healthcare policy would impact pre-existing conditions. A. Thompson said the group needed to determine whether to address existing healthcare law, or to adjust factors based on projections about future legislative changes. M. Ross-Russell noted that priority setting was planning for 2018.

C. Fields said that the Positive Women's Network (PWN) had met with health administrators at an event last weekend. She asked how the needs of women with HIV/AIDS were being addressed under Ryan White. A. Thompson stated that women's health would probably be in danger if the ACA was repealed. C. Fields noted that the state legislature of Pennsylvania had recently passed legislation regarding abortion. She stated that reproductive rights were important for women living with HIV. She added that access to PrEP was also important.

A. Ricksecker asked if a factor could be created specifically to protect services that were at risk if healthcare law changed. She said that the essential health benefit factor would behave as if the law wasn't changing. She stated that another factor could be added to protect threatened services like women's health. A. Thompson proposed that the expert panel help

determine what services may be threatened. N. Johns stated that the group could possibly put together a list of the services that were most threatened. She added that the weights of the priority setting factors could be changed. She said that as many as 6 factors had been used in the past.

T. Alexander noted that proposed changes in health care legislation were concerning, and some service categories would be hit particularly hard. He said it was important to plan for the worst case scenario. A. Thompson stated that access to some services, like substance use services, may be preserved. However, he said others, like services for transgender people, could be cut. He noted that all populations would be affected by changes, but some would be more than others.

M. Ross-Russell noted that priority setting made a statement about the values of the planning body. She stated that priority rankings were not directly related to funding. She said that it was important to consider people in poverty in Philadelphia, who would be disproportionately affected if they lost access to Medicaid. She noted that priorities needed to be based on factors whose importance could be explained. She stated that consumer need for services could be established in many ways, including the consumer survey and other data sources. She noted that bringing in experts could help validate what was already known about need but was unlikely to reveal dramatically different points.

A. Ricksecker agreed that the factors represented the values of the Planning Council. She stated that she liked the idea of including factors on emerging issues/vulnerable populations. She said that the need to address poverty would also come out in examining emerging and vulnerable populations. She suggested adding another factor that addressed potential shifts in healthcare law.

A. Thompson noted that, when he worked in another state, it was sometimes difficult to get numerical support for known community issues in priority setting. He said that known issues were prioritized in a special way, pending gathering of relevant data by the state. He stated that objective measures needed to be balanced by subjective measures, like experts. He noted that consensus had been used to measure the subjective importance of services.

A. Ricksecker stated that a factor could be generated by the Planning Council assigning a level of importance to each services. A. Thompson stated that, in the priority setting process in his former state, outliers from the group were asked to explain their positions. He said that using a consensus model had encouraged critical thinking and discussion.

A. Ricksecker stated that priority setting could also take into account what Ryan White could effectively fund. A. Thompson said the group could rank services individually and then discuss them together. He reiterated that a consensus factor may allow for this kind of discussion. M. Ross-Russell stated that consensus factors were used in the past. She said that consensus was not always reached and was difficult to represent numerically.

A. Thompson said that he found the combination of data and consensus to be powerful in terms of expressing values. C. Fields stated that in some community meetings she participated in, nay voters were asked to explain why they were voting nay. A. Thompson noted that, when there were disagreements about service priorities, dissenters needed to know that it was not personal. He suggested that ground rules be set for the discussion.

G. Keys stated that it was important that the priority setting process not be personal. She noted that some people did not take a broad view of the impact of each service. A. Thompson suggested giving objective data to start off the conversation. A. Ricksecker stated that ground rules could specify that rankings needed to be justifiable.

A. Ricksecker stated that she was opposed to visual voting. She noted that it sometimes allowed one person to influence another's vote. She suggested a model based on anonymous voting. She stated that, following tabulation, dissenters could be asked to speak out. N. Johns noted that there were clickers available for anonymous voting and feedback. However, she added that official Planning Council votes could not be taken using clickers.

N. Johns asked the committee to consider how the consensus factor would work, and how the Planning Council would be asked to contribute to the consensus.

A. Thompson suggested that the CPC take the quantifiable list and present it to the RWPC. He stated that the CPC could make suggestions about how to rank services personally regardless of the statistical ranking.

M. Ross-Russell stated that there were currently 4 priority setting factors. She asked if A. Thompson was proposing adding a 5th factor. She said that she understood him to be proposing a subjective component. She noted that, previously, 4 factors had been used to generate the priority list. She said any other factor that was added would need to have a percentage associated with it. She added that the factors could be changed and then sent to the RWPC for feedback. A. Thompson stated that the priority setting meeting could combine RWPC members and experts, and then balancing of factors could be done by experts and the CPC in conversation with one another.

N. Johns stated that the CPC could review the list of service priorities following the completion of the numerical ranking process. Then, any irregularities could be discussed with the RWPC. She said the Planning Council might request that the CPC do further investigation of why irregularities existed. N. Johns stated that adding in the 5th factor could be helpful.

S. Branca asked what kind of experts would be brought in to assist with priority setting. He noted that, unless experts were brought in for each service category, they may bias the process. A. Thompson stated that experts did not have to be specific to one service category. He asked the group if they thought there was enough expertise on the Planning Council to speak to each service category.

C. Fields stated that data was not always reliable. A. Thompson noted that data needed to be interpreted. He said that priority setting was based on many data sets, many of which were rigorous and sound. He stated that the Medical Monitoring Project (MMP) was one of these.

M. Ross-Russell noted that a technical expert panel could be used to speak to areas that the Planning Council did not have sufficient knowledge about. M. Ross-Russell noted that there would always be some issues with the way priority setting was carried out. She stated that the last priority setting process was highly numerical. She said that adding some subjectivity

back into the numerical process may be valuable. She suggested coming up with some percentages for factors and carrying out the process to see how it worked.

K. Baron noted that the last consumer survey factor had taken into account consumers who called a service "very important." She stated that this year's consumer survey did not contain the same question. M. Ross-Russell said that question 38 on the survey was intended to gauge need for services. She said the consumer survey factor could be changed to say "needed."

A. Thompson stated that he believed the continuum factor was important but limiting. He said that he believed 5-10% could be removed from the care continuum factor. He stated that 5% could also be taken from the essential health benefit factor. He stated that this would allow the subjective factor to have a 15% weight. He stated that 10% would be left in the essential health benefit factor and 20% in the care continuum.

A. Thompson asked S. Branca for feedback. S. Branca said had no issues with the factors. A. Thompson asked the group if they thought that the 15% weight for the subjective community consensus factor was too high. A. Ricksecker replied that she didn't. S. Branca noted that data was available on service utilization. A. Ricksecker added that service utilization data was included in the packet annually given out for allocations. A. Thompson asked if this service utilization data could be made available before the priority setting meetings.

A. Thompson asked if MMP data existed for unmet need. He suggested comparing utilization in funded service categories as well as unmet need from MMP data. C. Fields asked if utilization of Ryan White services varied among different areas of the city. A. Thompson asked if AACO utilization data could be broken down by city. C. Fields pointed out that many HIV provider agencies were concentrated in Center City. She said that some people in other areas of the city had unmet need. She stated that they had to go other places outside their neighborhoods to get their needs met. She suggested inviting in people representing agencies outside Center City.

A. Thompson pointed out that all meetings were open to the public. He suggested that all members bring the voices of people from their communities or invite them to meetings. A. Ricksecker noted that the Planning Council couldn't advocate for specific agencies.

A. Thompson asked the group if they had any feedback on the factors. C. Fields asked how the consumer survey factor was measured. A. Thompson stated that the consumer survey was currently wrapping up. C. Fields reiterated that some clinics didn't have staff to help clients fill out the survey. A. Thompson noted that sites were directed to help clients take the survey if needed. He noted that the consumer survey was reviewed and approved by many different committees of the Planning Council, including the Positive Committee.

Motion: A. Ricksecker moved, T. Alexander seconded that the 5 factors be adopted as follows: 30% Unmet Need, 25% Consumer Survey, 20% Continuum, 15% Community Consciousness, and 10% Essential Health Benefit. **Motion passed**: 8 in favor, 0 opposed, 1 abstained.

A. Thompson asked a member of the group to write definitions for the factors. He suggested that the group meet in advance of the next meeting to discuss the factors.

S. Branca asked when AACO utilization data would be needed. N. Johns stated that it would be needed next month.

A. Ricksecker noted that the staff had completed a tool in which each service category had a definition and its own scoresheet. She stated that, at their next meeting, the group could walk through definitions and factors to get everyone prepared for priority setting in May.

A. Ricksecker stated that the factors needed to be presented at an RWPC meeting. T. Alexander noted that many Planning Council members did not understand the priority setting process. He said that introducing the factors may help introduce the Planning Council to the priority setting process. A. Thompson stated that, after this introduction, Planning Council members would be encouraged to take part in priority setting.

A. Thompson asked if the group was ok with him drafting definitions for the factors. N. Johns stated that more work would be needed to figure out the scale for the consumer survey. A. Thompson said that he'd look into this process.

A. Thompson stated that he'd draft definitions and a brief explanation for each priority setting factor. He said these would be distributed by email in advance of the next CPC meeting. He stated that the factors would then be introduced at the following RWPC meeting. He added that the CPC would assess the sources used in priority setting at their next meeting.

M. Ross-Russell noted that the care continuum chart included in the packet was subjective, and developed by the CPC last time priority setting was done. A. Thompson asked if anyone had suggestions for a process for reconfiguring the care continuum. M. Ross-Russell pointed out that the group had developed the continuum by reviewing each service category one-by-one and discussing which steps of the continuum were addressed by each service.

M. Ross-Russell asked if AACO had any kind of data on services that directly correlated with the care continuum. S. Branca stated that they did have some data on how viral suppression and retention were impacted by each service category. He added that looking at data around the continuum may be useful, but would not be completely sufficient for creating a continuum chart.

K. Baron said she believed that the continuum of care developed last time priority setting was done had been based on where the service would be accessed along the continuum. She noted that, for instance, people get access to housing until they were linked and retained in care. N. Johns stated that the continuum also measured if the service helped people who had reached a certain point on the continuum. M. Ross-Russell noted that, for instance, housing assisted a person when they were retained in care. She added that housing also helped with viral suppression. She added that several other services, like substance use treatment and health insurance premium/cost-sharing assistance, could facilitate linkage to care.

A. Thompson asked the group if they felt comfortable with the continuum as previously established, especially considering that it was recently drafted. The group agreed by consensus to continue using the continuum as written.

C. Fields noted that housing was an important unmet need. A .Thompson encouraged C. Fields to come to the Comprehensive Planning Committee meeting in April and bring up her concerns. A. Ricksecker suggested that members of the group evaluate the continuum at their next meeting. She noted that she might like to change some placements on the continuum, if it were redone. A. Thompson stated that the continuum could be rethought after the group reviewed service category definitions at their next meeting. He asked everyone to look over the care continuum.

Old Business: A. Thompson asked to be kept apprised about the state's response to their letter. N. Johns said that the committee would be emailed as soon as a reply was received.

New Business: None.

Next Steps: N. Johns said that the group would continue reviewing the priority setting process at their next meeting, and the process would be carried out in May.

Announcements: A. Thompson noted that the National Quality Forum had recently reviewed their measures. He stated that the medical visit frequency measure was deemed to have insufficient evidence proving that the suggested frequency measured the desired outcome. He stated that the measure would be up for endorsement again in the future.

Adjournment: **Motion:** A. Ricksecker moved, K. Baron seconded to adjourn the meeting at 4:00p.m. **Motion passed: All in favor.**

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- February 16, 2017 Meeting Minutes
- Ryan White Services Along the Care Continuum 2015
- Service Priority Setting Worksheet 2015
- Consumer Survey Question 38 Responses
- Philadelphia EMA Planning Council FY 2015 Priority Setting Tool
- OHP Calendar