Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, February 17, 2022
2:00-4:00 p.m.

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

Present: Keith Carter, Debra D'Alessandro, David Gana, Gus Grannan (Co-Chair), Pamela Gorman, Gerry Keys

AACO: Michael Baldino-Kelly

Staff: Beth Celeste, Sofia Moletteri, Mari Ross-Russell, Elijah Sumners

Excused: Desiree Surplus

Call to Order: G. Grannan called the meeting to order at 2:15pm

Approval of Agenda: G. Grannan presented the February agenda for approval. **Motion**: K. Carter motioned, P. Gorman seconded to approve the February 2022 agenda. **Motion passed**: 4 in favor, 1 abstain.

Approval of Minutes *(January 20, 2022)*: G. Grannan presented the previous meeting's minutes for approval. **Motion**: D. Gana motioned, K. Carter seconded to approve the January 2022 meeting minutes. **Motion passed**: 3 in favor, 2 abstained.

Report of Co-Chair:

No Report.

Report of Staff:

S. Moletteri reported that there would be an Ad-Hoc Recruitment Meeting forthcoming and to look out for a Doodlepoll if anyone was interested in joining so that they can discuss the recruitment guidelines based on the comments from the Project Officer. M. Ross-Russell stated that she asked the Project Officer if allocations or priority setting would be impacted by the multiyear application process that happened for this budget year, to which they responded no it would not be affected.

Discussion Items:

–Priority Setting Process–

S. Moletteri stated that this process took place a maximum every three years and was to be

completed before allocations. This was a continuation of last month's priority setting meeting where Comp Planning went through each of the 29 service categories. Also, in the last meeting, there was some confusion around data of the Medical Monitoring Project (MMP). Those who attended the HIPC had a detailed presentation from Shareen Wise from AACO. There was discussion regarding if it was just medical record abstraction or were there surveys involved, etc. In the presentation they talked about how people who were 18+ had data collection in the form of a 45 min to hour long survey with an incentive of $50.

S. Moletteri stated there were four factors that went into Priority Setting. For this, CPC was going to use 2017 data because 2022 data would not be available in time and it would make sense to use the same scale for rating and measurement. Since the data wouldn't have changed from the last time priority setting was done for the Community Survey was in 2017. The last priority setting was 2019 so the same Community Survey data could be used. The new data has a lot of ratings of 3s and 5s, but mostly the former and it did not appear very balanced. This meant that when you rank priorities, they might be a bit close and therefore not representative. The highest percentage here was 23% need for dental services and that was on the low-range of 5. Nothing was close to 45% need or an 8 on the old scale, which may have made sense with the old data but it does not accurately portray the need.

S. Moletteri stated that they calculated the average of all the percentages of need and there were 13 not including the NA, which got an average percentage of 7.8. This number on the new, more balanced scale was indicative of average need, and the range between 7.9 and 15.7 which was labeled as "above average need" and anything equal to or above 15.8 would be priority need. G. Grannan stated that it was basically on a curve now. S. Moletteri agreed and stated that dental as an example would be ranked an 8 at 23.1% which was the same percentage, but bumped up.

P. Gorman asked if MMP was just for the city of Philadelphia, or the state of Pennsylvania? S. Moletteri answered that their understanding was that the Philadelphia jurisdiction was the information that was captured in the MMP. P. Gorman stated that she would look into New Jersey's MMP data to see if it was broken down by county as well. S. Moletteri stated that it would be helpful for the Community voices discussion as well because the category was going to take up 40% weight in the rating system.

K. Carter asked why treatment adherence was a 3, shouldn't it be a 1 on this scale because it's less than 7.8? G. Grannan answered that it was really a 6 on the scale, but there was a difference between 7.8 and nobody saying anything at all. M. Ross-Russell stated that the other thing that needed to be factored in was that when talking about chart extraction you're looking at the services that have been provided, and that are being identified within the chart extraction. So generally speaking, treatment adherence was also a component of medical care. If you're seeing that as part of the chart extraction, it may explain that, as opposed to the actual interview process. G. Grannan clarified that he meant it's a very important thing for the organization to be able to provide, but it doesn't mean that each individual patient's going to recognize its importance in their own case.

M. Ross-Russell added the other problem sometimes with services was that people don't necessarily recognize that it was a distinct service because it was folded into something else. People may not recognize that there was such a thing as treatment adherence because it was part of the discussion that happened when talking to a Case Manager or a primary medical provider.

K. Carter asked if the MMP data was necessary to make a decision? M. Ross-Russell stated that she believed the MMP data was important, because it looked at the difference between self-reported versus chart extraction versus people who were returning to care or who are new to care. These were three very distinct areas where you're getting an idea of what people's needs were and/or service usage. MMP is important simply because MMP is one of those factors that exists no matter what. It also provides us with a measure and a way of looking at how services were utilized, distributed, and incorporated into an office visit.

D. D'Alessandro added that limitations of the chart in an era of electronic medical records, which everyone used now, much of the charting was based on billable activities. S. Moletteri added that as much as chart abstraction was a part of MMP, there was also the 60 minute survey portion. Where they have people answer or answer more in depth questions. True, some things might be missed, which was why it was only going to be 20%. What you all have to say, and your experiences, since a lot of you were in the field or experiencing services, etc. that was going to hold the most weight at 40% of the scaling.

S. Moletteri asked the group if everyone felt comfortable with the new scale and if it made more sense to them. They also tallied the scores of service categories thus far and there were seven categories ranked 3, five categories ranked 5, and one category ranked 8. Moving on to CSU, there were a lot of 3s, 5s, and there were no 8s. Even though housing and transportation here were over 51%. What it was supposed to be for 8 is 51.7, based on the last scale, so they were off by a few tenths, but still did not rank as an 8. S. Moleterri shared that they added up all of these numbers and divided by 14, the number of service categories, and the average percentage was 22.9% and so that was going to be 3 or average need. For a rating of 5 on this scale the 23% to 45.9%. The range was also the average of 22.9 and that's going to be above average need, and then equal to or greater than 46% is going to be the priority need. With these changes these two 5s housing and transportation bumped up to an 8 or priority need.

S. Moletteri stated that the next portion was going to be a larger range because the numbers represented higher percentages captured for need via the Client Services Unit (CSU) for AACO. This CSU data, actually was different data than what CPC looked at last time. It's 2021-2022 and those were two separate charts broken out. The 2019 data that CPC looked at last meeting was presented using the old scale; there were only two changes from 2019 to 2020 and 2021. Medical care and medications both decreased in need, so much so that they dropped in rating based on the old system. They combined the 2020 and 2021 CSU data, and asked if CPC would like to see the two broken out individually. K. Carter asked what were the advantages and disadvantages of looking at each year individually. S. Moletteri answered that it was going to be the most recent data 2020 and 2021, and they thought it would be

advantageous to discuss what would be better to use the years averaged together or just one year.

D. Gana asked if CPC could see the years separately because there might not be as many differences as they might think. S. Moletteri answered that they were all fairly close, for example, Mental Health was at 31.5% need in 2020 and 35.6% need in 2021. M. Ross-Russell stated that the AACO wanted OHP to be clear about the data we were looking at. Simply put that the COVID-19 pandemic impacted the numbers and the numbers were a lot smaller than what they have been in the past. D. Gana asked what was the end in 2019? S. Moletteri answered 2,202. D. Gana stated that taking the average of these two years was a good idea because of the circumstances. The committee agreed and they continued using the 2020-2021 data averages.

S. Moleterri asked ahead of the next discussion item, if as CPC went through each of the service categories, would we want to rate them as each category was discussed or gather the information presented all in one meeting, and then rate them then? K. Carter stated that CPC may have to go back and get additional data or information and some of them the committee may not, so the ones that we can do, let's rank and the ones that we need to get more information, then just spend a little more time gathering. S. Moleterri stated that those ratings as a reminder will be part of the community voices section, and next month CPC would begin review of the service categories. M. Ross-Russell added the other thing about doing it this way, it allowed for the Community Voices piece. Additionally, it allowed for more input and people to think and say what it was that they felt about a given service as we moved forward.

–Integrated Plan–

M. Ross-Russell stated that OHP was proposing to provide CPC with the EHE Situational Analysis, as well as the Integrated Plan guidance. HIPC will be using the jurisdictional EHE Plan as the Situational Analysis. The epi profile, which is also something that is a component of the integrated plan should be completed by the time we have to include it. The bulk of this discussion item is going to be the expansion of the situational analysis. What that was going to really require was getting additional input and feedback from our regional partners because the situational analysis which was in EHE was specifically designed for Philadelphia County and the Integrated Plan was supposed to take into consideration all nine counties. It was probably going to be an exercise in figuring out how to take something that was already developed and creating a cohesive plan that represented all nine counties and acted as a road map for the Philadelphia EMA. It also meant taking into consideration all of the other disparate parts that exist out there currently.

K. Carter asked if there was an EHE Plan for New Jersey? M. Ross-Russell answered in most instances, with the integrated plan, it was understood that each state would have to do a statewide coordinated statement of need, which was representative of their plan. Because the direction for the last few years has been around ending the epidemic, whichever statewide coordinated statement of need plans that have been written by either New Jersey or Pennsylvania would have to have some component of ending the epidemic within them. If

you were asking, is there a specific EHE plan that the CDC funded, which was similar to what they funded in Philadelphia? It would have been for a specific county, as opposed to the entire state. Ending the epidemic was the direction that both HRSA and the CDC have been recommending and gotten behind for the last few years. K. Carter clarified that they were just seven states that have EHE plans with 40 cities within that.

D. D'Alessandro stated that in New Jersey, designated jurisdictions were Essex and Hudson Counties and none of them were statewide because they did it based on epidemiology of where most new cases that they wanted to stop. M. Ross-Russell stated that when EHE plans were originally funded and that was the direction it was city and county specific. The statewide coordinated statement of need was still an integrated planning requirement that all the states that received Part B, or CDC funds are supposed to have generated and created. D. D'Alessandro stated the CDC identified certain jurisdictions across the country based on their epidemiology; they had the most new cases of HIV to focus on their initial rollout of EHE funding. It'll change and expand because the epidemic changes. Right now, in our nine county region, the there are three EHE funded jurisdictions, and they're the counties of Philadelphia and New Jersey there were Essex and Hudson Counties neither of which were in the Philadelphia EMA. Only Philadelphia was funded as an EHE jurisdiction.

M. Ross-Russell stated the Integrated HIV Prevention and Care Plan Guidance, included the statewide coordinated statement of need. EMAs and TGAs were given the choice between whether or not they want to participate in each respective state that they may be in, in their statewide coordinated statement of need, which is supposed to represent their Integrated Prevention and Care Plan. Due to the fact that Philadelphia's EMA covered two states, that was why we chose not to participate because Philadelphia as a whole would not have anything. In order for this to work we would have to work with each of the states and obtain information specific for the regions that are part of this EMA that may have already been covered within their respective statewide coordinated statement of need.

M. Ross-Russell stated that using the situational analysis, which was Philadelphia specific, which already existed, which was reflective of the direction that the planning body had worked on previously with the grantee to try and ensure that this process was cohesive and have the community voice and everyone else involved in it. The situational analysis was probably going to be the meat and potatoes of our plan. It was just going to be a question of how to make it work and the things that we will need to take into consideration. S. Moletteri relayed that the plan stated it had to follow the goals of about 75% by 2025 and 90% by 2030. M. Ross-Russell responded that it was a combination of the requirements for the HIV National Strategic Plan and the requirements for the EHE, the goals we were supposed to try and achieve by that point and how we were going to get there.

M. Ross-Russell stated that once priority setting was done, we should also have the Consumer Survey and the EPI profile completed. We should have gone through on the care side, the allocations component, but we would switch to this to start including those components. We will be looking at the care components of the situational analysis in Comprehensive Planning, and looking at the prevention components of the situational analysis, and the Prevention

Committee. S. Moleterri stated that it was going to be “treat and respond” for EHE, which were Pillars Two and Four. Then, we would also look at Pillars Zero and Five. Pillar Zero was really about empathy, customer service, stigma, anti-bias and a lot of client-centric things. Pillar Five was focused on workforce development, so those would be supporting the Care Pillars, as M. Ross-Russell was just talking about.

K. Carter asked why there was both a National LGBTQ Health survey and the Consumer survey going out around the same time? M. Ross-Russell answered it was honestly the nature of just the way things sometimes tend to pan out. Additionally due to the pandemic things were pushed back from the federal government and the state government because it was assumed that the surveys would go out sooner. All of the plans that were originally put in place, the original EHE had a first set of goals that was supposed to be 2025, the next set of goals was 2030, and then a 2035 set after that. It's the same thing with priority setting and the Consumer Survey, we would have probably done the Consumer Survey this time last year.

S. Moletteri stated that after this meeting they would send the EHE plan as well as the Guidance which was currently being presented.

Other Business:

D. Gana stated that there was a round of harm reduction funding that just finished up.

Announcements:

K. Carter stated that the Reunion Project is going to be April 20th and 21st. They were finalizing speakers and times, and it was going to be virtual. One section first in the morning and the second section would be in the evening.

Adjournment:

G. Grannan asked for a motion to adjourn. K. Carter motioned to adjourn. D. D’Alessandro seconded the motion. The meeting was adjourned at 3:50 p.m.

Respectfully submitted,

Elijah Sumners