Meeting Agenda

VIRTUAL:
Thursday April 21, 2022
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(March 17, 2022)*
- Report of Co-Chairs
- Report of Staff
- Action Item
  - Priority Setting
- Other Business
- Announcements
- Adjournment

Comprehensive Planning Committee

Please contact the office at least 5 days in advance if you require special assistance.

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Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, March 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, Greg Langan

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 2:06pm

Approval of Agenda: G. Grannan presented the March agenda for approval. **Motion**: K. Carter motioned, C. Steib seconded to approve the March 2022 agenda. **Motion passed**: 5 in favor, 1 abstain.

Approval of Minutes *(February 17, 2022)*: G. Grannan presented the previous meeting's minutes for approval. **Motion**: G. Keys motioned, K. Carter seconded to approve the February 2022 meeting minutes with correction. **Motion passed**: 3 in favor, 2 abstained.

Report of Co-Chair:

No Report.

Report of Staff:

No Report.

Discussion Items:

–Priority Setting–

S. Moletteri stated CPC would begin to vote on priority setting beginning with three services and continue as suggested. The priority setting worksheet was updated and the data from the old Community Survey because the new data would probably not be available in time, the same scale used as last time. To get a better understanding, we created a scale that would distribute the ratings better throughout so that there weren't too many "3s" scores, or there weren't too many "5s" because there were too many "3s" so the percentages were changed. The CSU data from 2020 and 2021 were merged together. S. Moletteri continued that today

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was important because they would be going through three of the service categories and rating them a one, five, or an eight according to the predetermined criteria. A one means not critical to vulnerable populations, or emergent needs at this time. A five meant the service was critical for vulnerable populations and emergent needs, so critical service. An eight signified that this was a priority. Community Voices accounted for 40% of the weight for what each service will rate, so it carried the most weight when the scores were tallied.

G. Grannan asked if the chart S. Moleterri presented if somebody were on PrEP, and not virally suppressed, and they converted, would that be counted in this data? M. Ross-Russell answered this data was actually a representation of how infections were happening within Philadelphia. 39% of new infections were directly related to those individuals who did not know that they were positive. 36% was related to people who knew that they were HIV positive, but not in care, so essentially, those two higher percentages were individuals who were not taking any medication.

S. Moletteri continued that for other data, specifically for people who inject drugs and it was inclusive of MSM who inject drugs. Additionally, this information was present in Dr. Brady's EPI update, as per the graph the number of people has been increasing since 2016 and has gone up 251% from 33 people who inject drugs to 83 who were diagnosed with HIV in 2019. M. Ross- Russell added that the Medicaid chart or the Medicaid insurance charts that were available within Pennsylvania and then there was another one that was available for New Jersey, it was part of the services materials that we give out as part of allocations. What it was trying to show was that there were a number of services that were paid for under Ryan White services while they were also covered by Medicaid. The New Jersey information was not as comprehensive but would give some understanding of what the services that were available by the service provider or insurance providers.

S. Moletteri presented the key considerations and had the information broken down between age, race, gender, and sexuality. It was population based and the youth data ages 18-24 reported more high-risk situations as per the 2020 CDC behavioral data. 28.4% of men who were youth reported higher risk, and 18.4% of women the same age, so it was a little higher for men. K. Carter asked what were the high-risk situations? S. Moleterri answered not practicing safe sex, drugs, etc. were the basis of "risky" behavior. People's high-risk behavior, or reporting high risk situations went down as the age went up, so the percentages for all decreased over time.

S. Moletteri continued in 2019, people aged 30 to 39 accounted for 25.7% of new HIV diagnosis. And people aged 50 Plus accounted for 53.7 of total HIV cases. So, though the new cases 30 to 39, was the highest. While 25.7% represented the highest number of people currently living with HIV, this percentage was for people who were over 50 years old. There were more people aging with HIV. These were the demographic age groups to look out for right now.

S. Moletteri broke down the epidemic within the EMA regarding sexuality and gender. In 2019, MSM (men who have sex with men) made up the largest percentage of newly diagnosed and total PLWHA (people living with HIV) percentage in the EMA overall. This has been fairly consistent throughout the years.

However, percentages of total MSM/PWLHA was closely followed by the percentage of heterosexual PLWHA. Though newly diagnosed cases in NJ were higher amongst MSM, total percentage of PLWHA was identical between MSM and heterosexuals at 37.4%.

As for gender, a higher percentage of women and transgender women were living below the FPL than male RWHAP clients based on 2019 data. Overall, transgender clients were the most housing insecure, with 10.3% of transgender clients having temporary housing and 10.9% having unstable housing. Trans women, specifically, were most at risk for housing insecurity.

S. Moletteri reported that Transgender clients were the most housing insecure, so 10.3% of Transgender clients had temporary housing and 10.9% of transgender clients have unstable housing. This was the highest risk population for housing insecurity. And that only increased as we will see later, for if transgender women or transgender people generally, also were people who inject drugs. Key considerations around race in 2019, Black individuals accounted for the highest percentage of newly diagnosed people. This was in PA, New Jersey, and Philadelphia counties. In Philadelphia, the number of black individuals who are people living with HIV or AIDS is approximately 3.8 times higher than the next leading percentage. So there were 63.9% of people living with HIV or AIDS who are black versus 16.8% of people living with HIV who are white.

Nearly three quarters of Ryan White clients are from racial ethnic minority populations. There were 46.6% of clients who are black or African American 23.3%, who are Hispanic or Latino, and American Indian. Alaskan Native, Asian, Native Hawaiian, Pacific Islander and persons of multiple races, this was less than 2% for each category. White clients made up 26.6%.

M. Ross-Russell read the definition of “high-risk” from BRFSS: “I am going to read you a list. When I am done, please tell me if any of the situations apply to you. You do not need to tell me which one. You have injected any drug other than those prescribed for you in the past year. You have been treated for a sexually transmitted disease or STD in the past year. You have given or received money or drugs in exchange for sex in the past year.” Those are the three primary questions that they ask. G. Grannan asked if when they mention “drugs” if they included hormones? M. Ross-Russell stated she would have to check and get back with an answer. For people who inject drugs, there was a 151% increase in new diagnoses and people who inject drugs between 2016 to 2018. And once again, those numbers were 33 in 2016, and 83, in 2019. Men who have sex with men and transgender Ryan White clients who were also people who inject drugs had the highest percentage of temporary and unstable housing.

S. Moletteri stated the key considerations regarding finances and insurance, in 2019 60.7%, of Ryan White clients were living at or below the federal poverty level. Approximately 80% of Ryan White clients have some form of health care coverage. Most of Ryan White clients were covered by Medicaid at 3.8%. And that was followed by about 20.4%who had no coverage. There were 10.7% covered by Medicare 10% covered by a private employer, insurer or coverage, and then 10% that have multiple forms of coverage. K. Carter asked for the people who have multiple forms of coverage, are you saying that both Medicaid and Medicare are

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dually eligible? S. Moletteri answered that there might be a few different ways, but that could be one of them. M. Ross- Russell stated that she had additional data for the insurance breakdown as of December 2020, Medicaid was 47.8%, Medicare was 17.2%, private insurance was 20.3%, no insurance was 11%, and other was 2.8%.

S. Moletteri continued to key considerations for housing, approximately 7% of Ryan White clients have temporary housing and nearly 6% have unstable housing. So these numbers were averaged out from all the different populations. As for younger individuals, 20 to 34 years old, tend to have more temporary or unstable housing, therefore someone who's younger, who is also a transgender person and who also is a person who injects drugs, they are the poulations going to be the most at risk for unstable housing.

S. Moletteri continued to services and began with ambulatory outpatient care, medical case management, and dental care that would be ranked either a 3, 5, or 8. Outpatient Ambulatory Health Services provide diagnostic and therapeutic related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Allowable activities include medical history, taking physical examination, diagnostic testing, including HIV, confirmatory and viral load testing, as well as laboratory testing, treatment and management of physical and behavioral health conditions, behavioral risk assessment, subsequent counseling and referral, preventative care and screening, pediatric development, assessment and prescription and management of medication therapy. That is the definition of allowable activities.

According to the consumer service data, 7% needed this in the last 12 months and couldn't receive it. Approximately 80% of Ryan White clients have insurance and about 41.5% were covered under Medicaid/Medicare. In 2019, 43% of people living with HIV were co-infected with hepatitis C, and it was resolved. Although progress has been made barriers for transgender patients and patients aged 20 to 34 still exist, reflected in retention and care disparities. Those goals have not been met, for retaining Trans patients and patients who are younger than 34. Those are the most difficult to get and stay in care. S. Moletteri opened the floor to committee members to speak about their experience with outpatient care.

G. Grannan asked if it was the case that emergency room visits are not allowable, even if the emergency is caused by the disease process of HIV or AIDS? M. Ross-Russell answered everything that happened outside of the hospital programs and services were not necessarily funded. There were service providers who work within hospitals, who were funded to provide services within hospitals, but they have grants specifically for ambulatory outpatient care and other services. They were medical providers who happened to be working within the hospital setting, but generally speaking, services provided within the hospital emergency room were not covered by Ryan White. Five people voted that it is the highest priority and it is an eight.

S. Moletteri stated the next group to be voted on was going to be medical case management, these were all core medical services. Medical case management is the provision of a range of client centered activities focused on improving health outcomes in support of the HIV care continuum. Key activities include assessment of service needs, development and reevaluation every six months of an individualized and comprehensive care plan, client monitoring and

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advocacy and treatment adherence counseling to ensure readiness to adhere to complex HIV treatments. 2017 consumer survey data stated that 82% respondents had a medical case manager and 96% were satisfied with their medical case manager. Consistent with the goal those who were not virally suppressed were more likely to have a medical case manager.

S. Moletteri continued that medical case management was the third most used service. This was because the purpose of this services to help individuals access other services they needed. It also supported the systems care continuum. The program guidance for medical case management was to improve healthcare outcomes with a focus on ensuring readiness and adherence to HIV treatment. G. Grannan asked how many MCMs there were in the Philadelphia EMA? S. Moletteri answered that they could not find the amount of MCMs, just the agencies and providers with them on staff, but that the numbers could be in flux due to turnover.

C. Steib asked if we get 100% on the highest ranking and it ties with the other category? How has that been resolved in the priority setting? S. Moletteri answered that it doesn't need to be resolved today because there would be a full a priority setting chart that includes CSU data, rankings, as well as MMP and also the consumer survey data, so the numbers would change with the weight of the other rankings. Medical Case Management received one 5 and five 8s.

S. Moletteri stated that the last category was dental care or oral health care. oral health care activities include outpatient diagnosis, prevention and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists licensed dental assistants, it did not have any program guidance like the others did. The 2017 Community Survey data stated that 11% reported needing, but not receiving dental services and 30% did not have dental insurance. M. Ross-Russell stated that dental care was funded under Ryan White Part F, Part A, and could be funded under Part B. Most FQHCs and/or health centers could also provide low cost or free dental care and another consideration was most Medicaid covered dental services. G. Keys added Philadelphia Department of Health, health centers do have free low-cost or insured dental care to City of Philadelphia residents. There were some procedures that were not completed on-site and we referred to the dental school.

S. Moletteri read the results of the vote: one 5 and five 8s which was the same as the MCM category breakdown. Next meeting won't focus on the key considerations and other superfluous information. There were 25 categories left to vote on which could be done over the course of 5 more meetings. They suggested adding another meeting per month to get through the priority setting faster. G. Grannan asked if CPC could try more categories next meeting and see how that works? S. Moletteri asked if the goal would be to complete as many as possible per meeting or set a number to complete? C. Steib suggested voting on 7 categories to complete this before allocations.

–Integrated Plan–

S. Moletteri stated that the group would be looking at the situational analysis from EHE and seeing how it could expand to the counties, specifically pillars zero through five that already exist in the EHE plan, and see how we can work from that. M. Ross-Russell stated that there

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was a meeting with the Recipient and others from AACO and the first meeting was scheduled right before the next comp planning meeting. A part of the discussion is to figure out how to incorporate the planning body into the integrated plan process.

M. Ross-Russell continued that moving forward from looking at the frequently asked questions, as well as some of the other pieces that a lot of this was going to be leaning very heavily towards the EHE and the HIV National Strategic Plan. New Jersey was going to try to do a statewide coordinated statement of need, where all of the directly funded TGAs and EMAs work together to try and create a cohesive and comprehensive document as opposed to several different documents. Philadelphia's EMA, although multistate, was going to do a single city integrated plan, but we need to work with the recipient and find out what direction and what things they think we need to focus on as a planning body and as the planning body staff.

Other Business:

None.

Announcements:

None.

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 3:58 p.m.

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