Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, January 20, 2022
2:00-4:00 p.m.

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

Present: Keith Carter, Lupe Diaz, David Gana, Gus Grannan (Co-Chair),

Pamela Gorman, Sharee Heaven, Gerry Keys

AACO: Michael Baldino-Kelly

Staff: Beth Celeste, Julia Henrikson, Sofia Moletteri, Mari Ross-Russell,

Elijah Sumners

Excused: Debra D'Alessandro

Call to Order: G. Grannan called the meeting to order at 2:06pm

Approval of Agenda: G. Grannan presented the January agenda for approval. **Motion**: K. Carter motioned, G. Keys seconded to approve the January 2021 agenda. **Motion passed**: 4 in favor, 1 abstain.

Approval of Minutes *(November 18, 2021)*: G. Grannan presented the previous meeting's minutes for approval. **Motion**: K. Carter motioned, D. Gana seconded to approve the November 2021 meeting minutes. **Motion passed**: 4 in favor, 1 abstained.

Report of Chair:

No report.

Report of Staff:

M. Ross-Russell reported that OHP has received a notice of partial award which meant that AACO was in a continuing resolution, so in order for services to continue HIPC would need to do a level funding budget for the partial award. For the Planning Body, that means they were going to be doing their allocations and it would be based on the level funding budget. When OHP receives the final notice of award, we will do whichever allocation was closest; either level-budget, a 5% decrease, or 5% increase budget. M. Ross-Russell also reported that the exemption was approved by the IRB and OHP staff was currently in the process of creating packets and asking providers and organizations to help in the distribution of the Community Survey. S. Moletteri reported that the Community Survey had been translated into

Spanish since the last meeting.

Discussion Item:

–Priority Setting–

S. Moletteri reported that priority setting was to be completed every three years, or as needed, whereas allocations was done annually. The last time priority setting was done was in 2019, and its main purpose was to see which Ryan White services HIPC deemed a priority. Rating something lower versus higher does not mean any of the services were unimportant, rather it was about considering what services were most important to the care continuum (i.e. diagnosis, linkage to care, retention to care, and viral suppression) This was separate to allocations in the sense that priority setting does not deal with money and priority setting can inform our allocation of Ryan White Part A dollars, but it was not going to be discussing money during this process and we were not going to let allocations inform priority setting.

S. Moletteri reported that the goal of this meeting was to rank the priorities of all Ryan White Part A funded service categories which included core and support services. This meeting was just to review everything and look back at changes made in 2019 to determine if the committee was still comfortable with those priorities. S. Moletteri continued that for the service priority categories the committee should consider four things, first of which was the Community Survey. As M. Ross-Russell had previously mentioned, OHP was hoping to get a new Community Survey data back and analyzed, so it can be considered in HIPC's priority setting in 2022, but if it was not returned we would use the last Community Survey. That would account for 20% of the decision when doing priority setting and the percentage breakdown would become clearer as this meeting continued.

S. Moletteri continued that there was the MMP, the Medical Monitoring Project, which was a surveillance system that was used to monitor behavior and medical record data. It captured unmet service needs for PLWH in care, and also accounted for 20% of the decision when conducting priority setting. There was also the Client Services Unit: Youth Intake, and this was self-reported with clients. This was the AACO hotline for Case Management, so case management was not really considered because 100% of people calling in met that. However, it was inquiring about the need for other services as well. Next, was community voices, so these were going to be our discussions during priority setting and how members present ranked it based on the scale of one, five and eight. In 2019, this did change, it now has 40%. As in 40% of what the priority would be based on what present members think. To inform community voices was going to be based on disparities and the EMA care continuum, so diagnosis, retention, and viral suppression and data around that. People living with HIV insurance status and income, additionally there would be comparison of outcomes in people living with HIV who use Ryan White services versus all people living with HIV within the

EMA, and service utilization data by insurance, age, race, ethnicity, region, and gender.

S. Moletteri stated that Ryan White outcomes were measured by service and past discussions that have taken place in Comprehensive Planning or HIPC, and any qualitative data or discussion that members thought was important. They reiterated that if something was rated a "one," so "not critical to vulnerable populations, or emergent needs at this time." That does not mean that this was an unimportant service, it just meant that it was not currently a priority, based on the care continuum and health disparities. M. Ross-Russell stated that Community Voices was also a category that was created to take into consideration the expertise and knowledge of the people who were participating in this process. There were a lot of things that were data driven throughout this process, but then there were also things that as providers, or people who utilize the service, your interpretation of that particular service may not be in line with the way that the data was presented. We wanted to make sure that the voice of the community could be included in this process, and that you could bring your experience and expertise to the discussion. So Community Voices was one of these things where it involves a lot of community input as we go through and discuss each individual service.

S. Moletteri agreed and stated that one important thing to note was that qualitative data from people and their experiences was just as important for the creation of this set of priorities. They presented the meeting packet from 2019's priority setting meeting because the percentages have changed. As of this meeting 40% was accounted for Community Voices, so that was going to be the most important for priority setting and the rest were 20%. Prior to that, there were the Essential Health Benefits, and as per the discussion from 2019 this was removed because not everyone has access to health insurance and that there should be more focus on people not covered by insurance and that insurance coverage should not really affect the ratings. Essential Health Benefits used to account for 10% and this changed the weight that each category had and now Community Voices has more at 40% and the layout was different generally.

M. Ross-Russell added that the reason the category was present as part of priority setting previously had to do with taking into consideration Ryan White was the payer of last resort. The implementation of the Affordable Care Act altered accessibility for people who were around 138% of the poverty line. Essential Health Benefits was trying to also take into consideration that there were a lot of services and other things, which could be supported through the Affordable Care Act and other funds that currently exist. S. Moletteri stated that those percentages have been redistributed as M. Ross-Russell pointed out.

S. Moletteri presented the rating for Community Voices was on a 1-5-8 scale. So "one" represented non-critical, "five" was the "service is critical for vulnerable populations and emergent needs" and "eight" was "the service is currently priority need for vulnerable populations and emergent need." It was not a traditional 1 through 10 scale, just those three options, one, five and eight. For the Consumer Survey, MMP and CSU, it's 1, 3, 5 and 8, so it's a little different than the Community Voices scale. M. Ross-Russell added that this was

just because those three categories, the consumer survey, MMP, and client services at intake were based on a very specific scale; those numbers were generally filled into the Excel file.

G. Grannan stated that when this was done in 2019, the ranking system was done with color coded cards. S. Moletteri suggested that they use a poll to vote. D. Gana stated that they broke into smaller groups to discuss the rankings in 2019. K. Carter responded that because the group was already small it would be easier to do as one, but the CPC could also do this over the course of two meetings. G. Keys stated that group input was documented on the whiteboard when they last met about priority setting. S. Moletteri agreed with K. Carter that this could be completed over the course of more than one meeting because the priority setting had to be completed before June due to allocations.

M. Ross-Russell suggested that the thing that was going to drive priority setting was the Community Survey, and whether or not there were enough responses. G. Grannan asked if HIPC was constrained by allocations and its deadline? M. Ross-Russell responded that when meeting with the project officer, January 24, the thing that is unclear was that historically, OHP submitted an application annually. The last application that went in for funding year 2022, which was this year, which would start March 1st, was a multi-year application. So OHP asked at the time, what does that mean about allocations? We don't know yet how we're supposed to do or whether or not there were any significant changes because it was a multi-year application to the allocations process. She stated that she would ask the project officer on Monday, what that means for the Planning Body.

G. Keys asked what was the timeline for the Community Survey to be distributed? S. Moletteri answered that OHP was planning for February for distribution. M. Ross-Russell added that OHP also needed to receive the proper provider list from the recipient from AACO. There was supposed to be a letter, which went out to all of the providers alerting them that this is coming. She still has not gotten the provider list, because part of what needs to happen was that the providers need to be alerted that this was coming. They would probably also get the link to the online survey and other information so that they could actually distribute it but then we have the mailers, the packets, and we need to talk to providers and find out how many packets they want. So that we can drop them off so that they'll have them and it was a complete package with which was postage paid. Coming and going. OHP was still working on trying to get that done by the end of the month. And yes, probably beginning February it should be going out. OHP was asking for a return by May. As the surveys returned completed, M. Ross-Russell would begin the data entry for SPSS, and it was complete and then it crashed. All in all, we were looking hopefully at having everything set up by next month.

K. Carter stated that his concern was the distribution of packets to providers and then disseminating it to clients. We have to hold them accountable to actually get five completed and returned. G. Grannan responded that CPC also want to make sure we were not shifting the workload on to non-profits who basically were doing us a favor, and there has to be a balance that was certainly worthwhile consideration. M. Ross-Russell clarified that what HIPC was

asking providers to do was if they have a mailing list to stick a label on, and just drop it in the mail. That was so that when we actually gave it to the provider, it was a fairly complete packet. In some instances, it is up to the provider if they want to include a sample cover letter that OHP could provide that could go on their letterhead. The Office of HIV Planning ensures that there is little to do on the provider level and that OHP were trying to give them something that was fairly easy to send out. The goal was to try to make sure that OHP took on the lion's share of it before it goes out the door.

G. Grannan pointed out that there needs to be other approaches or your population sample was going to be skewed to only people who have mailing addresses. M. Ross-Russell answered that that was true and that was the reason why we were also enclosing, in the information that we were sending to people, fliers that have a QR code on it. It also had an information where people can potentially if they have a smartphone where they could use a QR code and go back to the online survey. We also asked providers if they want packets that were handed out so they do not have to be mailed. That is for the purpose as well so they can have the packet at their front desk.

D. Gana asked in regards to the QR code and doing it on a phone, hypothetically if there were a case manager doing foot outreach, if they let somebody use their phone to scan the QR code, and do the survey, would that be the only survey that can be done from that phone number? M. Ross-Russell answered that she does not think that would be a problem. Additionally, OHP was also setting the survey up so that it could be sent to people as a link via email, so that they would have the link, if they want to send it out to people. That way, they can take the online survey and use the link via email. K. Carter asked how long the survey was expected to take to complete? S. Moletteri answered 30 to 40 minutes, it was previously 20 to 30 but a few more questions were added.

S. Moletteri presented the priority setting tool from 2019 to the Comprehensive Planning Committee with a comparison to 2017's priority setting tool to show the group how it would be set up. All of the service categories highlighted in yellow had a change of five or more in their ranking, just to show how things can change in two to three years. People found that there were different priorities. For example, Mental Health went from ranking #12 in 2017 to #5 in 2019. M. Ross-Russell stated the reason why they were identified in yellow was because those were the service categories that OHP had to explain why they moved. Historically OHP has had to explain why they moved as part of the application submission, so we identified which service categories saw the greatest change, and then we had to explain why they changed. It still was because these rankings were also submitted, or were submitted as part of the application.

K. Carter asked how was CPC going to have this priority setting done without having COVID-19 skew priorities if the last one was completed prior to the pandemic? M. Ross-Russell answered that was part of the consideration and part of the concern, even with the Community Survey. That was the reason it got so much longer because we tried to add things

to it that would take into consideration pre and post-COVID. To answer your question, yes, COVID was definitely going to have an impact on the priority setting and we would just have to explain it. K. Carter asked if this set of priorities would be in effect until 2025? M. Ross-Russell answered not necessarily because the priority setting tool agreed upon to do at least every three years. Once the world shifted back to relative normality, the planning body may decide to go back and redo priority setting. Historically, priority setting has been done whenever there was something that happened in our service environment that was large enough to shift the way things were done and how the community responded to certain things.

S. Moletteri continued explaining the chart. MMP, Consumer Survey, and client services that was the three columns to the right of the service category and each have a weight of 20%. These were all predetermined numbers based on the percentage of people who reported need for each of these different services. They're assigned 1, 3, 5, or 8 based on the percentage of people who need it. Then, Community Voices was the heftiest part of this process as M. Ross-Russell previously stated. COVID-19 will also impact that conversation and was inevitably going to be part of this process, and our considerations. For example, for the first row, it has 13 members voting, and 9 of those 13 members voted that it was the highest priority, 4 voted that it was a priority, and 0 voted that it was not necessary to consider it a high priority at the time. That was why it landed in first, and that is the Housing Assistance category. The score average is 7.08, so that was going to be out of 8, because 8 is the highest score that a category could have. And that's 2.83 is the weight 40% of that of the total, and then adding up MMP, Consumer Survey, Client Services Unit. Considering all of those and Community Voices, it got a total of 6.43 out of eight, which was at 80.38%. So it got 80%, and that's what got it in first place.

K. Carter asked how many service categories there were? M. Ross-Russell answered that there were 29 categories. G. Grannan asked although there were 29 categories, we do not fund all of them, correct? M. Ross-Russell answered affirmatively. S. Moletteri stated that OHP could make PowerPoints to summarize some data for the committee that could help get to the points that they want to hit, or the important things that they need to say about each service. It could help to expedite that process, if we had information readily available. If there were any suggestions for presenting the information for each of these discussions. Would everyone think we should have a worksheet that people could fill out beforehand? K. Carter responded that we were not talking about money during ranking these, if you were not funding a service category, he doesn't want to have to deal with ranking it. M. Ross-Russell responded that she would be hesitant to exclude service categories. The whole point of Ryan White is that it's funding of last resort. There may be important services that have consistently been funded through other funding means or because it is generally supported by public health insurance, private health insurance, etc. Having said that, it was important to recognize all of the services and where they fit based on community input. There were services we don't fund that people talk about meeting as part of the client services at intake.

D. Gana stated that a good example of that is childcare right? It was a priority to get people

engaged in the care continuum. S. Moletteri continued presenting the priority setting chart. They stated that they have left out the Consumers Survey ranking, because we were not sure which one we were going to use yet. You have the CSU and the MMP and that was weighted. The CSU was updated in 2019, so we used the 2016 CSU data in the 2019 priority setting process, and the MMP was the 2015 to 2018 cycle. The categories were not in order right now, but each service has a little ranking next to it, so 30.5% translates to number five ranking for Medical Care, and then for MMP medical care 7.6% translates to a three ranking.

P. Gorman asked if S. Moletteri could reiterate the scale. S. Moletteri responded that one was less of a priority, and eight was highly prioritized on the 1, 3, 5, 8 scale. For MMP, if there's no mention, it's automatically rated as a one. If it's 1% to 20% need it was rated as a 3, 21% to 50% need was rated as a 5. If it was over 50% need it was rated as an 8. They pointed out that, regarding MMP, the rating based on need percentage that was assigned here, there were a lot of three's, so did the group want to reconsider this scale? M. Ross-Russell stated that if you were going to reconsider the scale, you probably need the MMP data so that you can determine what makes the most sense in creating the scale. Because it's not just something it's not a number that was arbitrarily picked. It was looking at all of the responses and the number of responses or the percentage of responses overall, for each and every individual service. So you probably need to have the data in order to figure out how you want to, you know, alter that scale. G. Grannan stated that he recalled something analogous happening when the group previously potted up our own scores. Three ended up kind of being the, you know, mean, if you add one and eight divided by two, you're pretty close to three.

P. Gorman asked how does the denominator of the Medical Monitoring Project impact the weighted score due to it being higher? M. Ross-Russell answered that it was about five years worth of data and believed that was why the number was so high. P. Gorman stated we were going to do a comparison like this, we should probably just note what the differences were in the different ratings, for the sample sizes and the time period that the information was collected.

S. Moletteri asked if there was anything else CPC wanted to focus on regarding getting the process up and running in discussions before they actually dig into the services? M. Ross-Russell stated if the application was due in September or October, the latest that we would have to have it done would be August. All of this is dependent on what it is that we have to submit as part of the application. K. Carter asked if this needed to be completed sooner rather than later? M. Ross-Russell answered that she thought that there was some level of flexibility, but she needed to get some clarity about the expectations. This was because the most recent application was not as intense as it was in the past as far as the amount of information or the amount of detail that we as the planning body had to provide. It all depended on what we had to submit and when. The bottom line to it was that the time period for when all of our work generally has to be done is usually the end of September HIPC meeting, which included allocations.

Any Other Business:

None.

Announcements:
None.

Adjournment: G. Grannan called for a motion to adjourn. **Motion**: L. Diaz motioned, P. Gorman seconded to adjourn the January 30, 2021 Comprehensive Planning Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:45 p.m.