Comprehensive Planning Committee
Meeting Minutes of
Thursday, March 16th, 2023
2:00 p.m. – 4:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Keith Carter, Gus Grannan (Co-chair), Gerry Keys, Pamela Gorman

Guest: Sanzida Anzuman (DHH), Gita Krull-Aquila (DHH), Nina Tao

Staff: Sofia Moletteri, Mari Ross-Russell, Beth Celeste, Kevin Trinh

Call to Order: G. Grannan called the meeting to order at 2:05 pm.

Introductions: G. Grannan asked everyone to introduce themselves.

Approval of Agenda:
G. Grannan referred to the March 2023 CPC agenda and asked for a motion to approve. **Motion:** K. Carter motioned; G. Keys seconded to approve the March 2023 Comprehensive Planning Committee agenda via a Zoom poll **Motion passed:** 3 in favor. 2 abstaining. The March 2023 CPC agenda was approved.

Approval of Minutes (*February 16th, 2022*):
G. Grannan referred to the February 2023 CPC minutes. **Motion:** K. Carter motioned; G. Keys seconded to approve the February 2023 meeting minutes via a Zoom poll. **Motion passed:** 3 in favor. 2 abstaining. The February 2023 CPC Minutes were approved.

Report of Co-chairs
None.

Report of Staff
M. Ross-Russell reported that the Prevention Committee would review the maps on the Office of HIV Planning (OHP) website. S. Moletteri would send the maps to the committee in an email. She asked for feedback on what information within the maps was helpful or not helpful.

Presentation:

–Quality Management Plan–
G. Krull-Aquila from the Department of HIV Health (DHH) introduced herself and said she would continue her Quality Management Plan presentation. G. Krull-Aquila had previously presented this topic in the previous HIV Integrated Planning Council (HIPC) meeting. G. Krull-Aquila wanted to ask HIPC three discussion questions, but she could not due to time constraints. G. Krull-Aquila thanked M. Ross-Russell for inviting her back to allow her to start

the discussion. G. Krull-Aquila said she had abbreviated the presentation and added more information regarding the action steps to their Quality Management (QM) Plan goals.

G. Krull-Aquila thanked S. Anzuman for her work on the QM Plan. S. Anzuman announced that she would leave the Department of Human Services (DHS) after 4 years of service. She said her final day of employment with DHS would be March 30, 2023. She thanked the committee for inviting her and appreciated working with everyone.

She gave a brief overview of the agenda. The presentation would comprise an overview of the QM Plan, followed by a QM Plan Work Plan presentation and a discussion session.

G. Krull-Aquila said the goal of the eligible metropolitan areas (EMA)'s QM was to use quality data to improve access to high-quality HIV care. She said DHH's QM program has activities spanning all aspects of the HIV care continuum. G. Krull-Aquila referred to a chart displaying the activities that made up the DHH QM Program. The DHH QM consisted of performance monitoring, quality improvement projects (QIPs), and capacity building. G. Krull-Aquila explained that performance monitoring consisted of DHH performance measure reports (PMRs) and appointment availability calls. She said that DHH would incorporate QIPs into their Medical Case Management (MCM). She said they were looking to do QIPs with their status-neutral programs. They perform technical assistance and training on performance measures.

DHH's QI principle was that the consumer defined quality. She said the Ryan White system was built on consumer contribution, participation, feedback, and advocacy. DHH hoped to increase consumer priority in the coming year for all steps of the QI process. The QM Plan was written by the QM Advisor, S. Anzuman, and the QM Coordinator, G. Krull-Aquila with input from the DHH units when needed. G. Krull-Aquila said they aimed to create a more streamlined and concise plan to release to their stakeholders in 2023. She said when she started working on the QM Plan in June 2022, it was over 80 pages long.

G. Krull-Aquila reviewed the components of the QM Plan. The components of the QM Plan were organizational summary, quality statement, quality infrastructure, annual goals and objectives, participation of stakeholders, performance measurement, capacity building, evaluation of QM program, work plan and process to update QM Plan.

She described the components of the QM work plan. She said they had to list their goals. Then they would need to list the objectives for each goal. For each goal, they would also need to create action steps to achieve each goal. Within each action step, the QM Plan would describe the specific activities, the staff responsible for each activity, and each outcome's time frame.

K. Carter asked if there should be two separate plans for the providers and the consumers. G. Krull-Aquila asked S. Moletteri if they should field questions during the presentation. S. Moletteri suggested that answering questions during the presentation would be helpful so they would not need to backtrack at the end. G. Krull-Aquila returned to K. Carter's question. She replied that they could not have two separate plans since consumer feedback was vital to the plan.

G. Krull-Aquila reviewed the goals, objectives, and action steps of the QM Plan. The first goal was to evaluate, build upon and expand clinical quality management (CQM) infrastructure and activities supporting the End the Epidemic (EHE) goals.

The first objective was to monitor and evaluate improvements in access to and initiation of status-neutral HIV treatment and care. To achieve this objective, she said DHH would gather, monitor and analyze data obtained from low-threshold HIV treatment site visits using a database called CAREWare 6. The next step would be to monitor program activities by collecting and evaluating regularly scheduled provider reports to ensure program implementation met the local EHE goals. The third action step would be to employ an outcome measure for Immediate Antiretroviral Therapy (iART) at all DHH-funded outpatient ambulatory health service (O/AHS) programs. The next action step would be identifying EMA-wide disparities in the Ryan White database by race, age risk, and insurance status.

G. Grannan asked what the term "status neutral" meant. S. Anzuman explained that "status neutral" meant that they provided service to a person regardless of their HIV test outcome. If a person had tested negative, they would be given prevention information such as pre-exposure prophylaxis (PrEP). If a person had tested positive, they would be directed towards HIV medication and therapy such as iART. The reason why they had used the term "status neutral" was because they wanted more people to get tested and know their status. G. Grannan thanked S. Anzuman for her explanation.

K. Carter noted how DHH wanted input from the community but questioned how the community would know if the issues the community had raised were addressed. He asked how they would communicate the process and action steps taken to address the problems to the community. G. Krull-Aquila said this was addressed within the Work Plan section of the presentation and would soon get to it.

G. Krull-Aquila returned to the action steps of the first goal. She said they would present the disparities at the annual QM meeting. They would then modify the public-facing EHE dashboard to present unblinded provider-specific information on viral load and retention in medical care.

G. Krull-Aquila said the second objective of goal 1 was to apply a QI perspective to review and provide feedback on Corrective Action Plans (CAPs) submitted from providers with identified issues during bi-annual DHH appointment availability calls. The first action step to achieve this goal was to conduct O/AHS appointment availability calls twice a year in English and Spanish. DHH would analyze these calls and provide feedback reports to the staff. DHH called these "secret shopper" calls to test if a new client could schedule an appointment. The next action step would be to receive the CAP from program analysts for programs with issues and complete a CAP review form. Quality specialists would then communicate with program analysts regarding CAP and offer suggestions for resources, metrics to monitor or action step modifications as needed.

K. Carter asked if this was a site-specific action plan. G. Krull-Aquila replied that the CAP was a site-specific action plan. She described an example where a hospital could not provide a client with a timely appointment. She said the hospital would then need to complete a CAP form. QI analysts would then review the form and decide if improvements could be made to improve the service.

S. Moletteri asked if they could check the appointments' results and measure each client's satisfaction. G. Krull-Aquila said they had focused on getting the client an appointment date. She said they pay attention to the events of the call and any barriers that may block the client from receiving services. She added that they do not have a way to review what happens during an appointment. G. Krull-Aquila explained that they do not save the information once a call has been made since they want to focus on helping other people find appointments.

K. Carter asked if they had recorded the calls for quality improvement. He said if they could measure the call like other call centers, they could improve client experience. G. Krull-Aquila explained that they could not record the calls. She said there were certain parameters that they looked for when listening to calls. DHH looked at parameters such as how long it took to receive an appointment date or how long the client was put on hold. S. Anzuman said that when they listen to calls, they have a form in front of them where they document everything. She said that if an agent was rude, they would follow up with that agent. She said they document everything including good and bad interactions such as the number of transfers, the agent's professionalism and the repertoire between agent and client. S. Aznuman clarified that her department does not record the calls but the program department of DHH did record their calls.

G. Krull-Aquila said evaluating the quality of the appointment was the provider's responsibility. G. Keys said that while she agreed that evaluations were beneficial, she recalled from her experience that the "secret shoppers" would sometimes antagonize the staff. She said people have been paid to come in and request an HIV test. G. Keys said that once a person has requested an appointment, that record was legal whether the appointment was finalized or not. This legal record could not be deleted. G. Keys said this had caused problems while working in the ambulatory service. They had to contend with a record that was not a true appointment. K. Carter said he understood this had interfered with their records and metrics. G. Keys said they could delete the record but they could not delete the patient information and the record that an appointment was made. That person would be considered a patient of the provider.

K. Carter asked if they could have someone at the provider site to follow the "secret shopper" when they reached their appointment. He said they could observe and ensure that the quality of medical care was adequate. G. Krull-Aquila explained that they were focusing on helping a newly diagnosed person with HIV or a person lost to care to get an appointment as easily as possible. G. Krull-Aquila said confirming the appointment was just as important as the appointment. K. Carter suggested that the "secret shopper" should bring an evaluation sheet to fill out. G. Krull-Aquila agreed that DHH should look into this idea. She said that the idea could be good to foster collaboration between DHH and providers. S. Anzuman thanked K. Carter for his idea and said it could be a way to incorporate consumer feedback.

G. Krull-Aquila referred to the third goal. The goal was to re-evaluate barriers reported by patients re-engaged in care through Field Services and incorporate results into the CQM program including provider QI projects. The first action step for this objective was to collect information on the barriers to care experienced by patients. The second action step was to develop data-to-care (DTC) feedback reports and disseminate them to participating O/AHS providers biannually. The next step would be to provide a monthly list of those who were either not in care or were not virally suppressed to HIV providers where the client last had an appointment.

G. Krull-Aquila proceeded to Goal 1 Objective 4. The objective was to initiate QIPs with DHH-funded prevention and MCM programs using the coaching model to improve performance across identified areas. The first action step was learning about prevention initiatives by training and reviewing program reports and procedures. The next step was to meet with prevention providers to learn about programs and any implementation issues. The third action step was to provide training and technical assistance to prevention programs while conducting QIPs. Then they would evaluate the prevention QIP outcomes. DHH aimed to provide introductory training to MCM providers on DHH QM, QIP process and the new coaching model. The final action step for goal 1 objective 4 was to disseminate 2023 QIP outcomes to providers, the regional CQM committee, DHH staff and relevant stakeholders.

G. Grannan asked if they had integrated the availability of training into their QIP and CAP. He said it would be unfair to providers if they were reprimanded for something they were not properly informed about. G. Krull-Aquila assured G. Grannan that they provide substantial training. She said that the first step in the coaching model was to discern the needs of each program to allow DHH to tailor their training to each provider. G. Krull-Aquila said if they could not provide the training, they would connect the provider to the resource they need.

K. Carter asked if there was a way to measure the quality of care for minorities at places such as the ER. He said many people do not have insurance and he wanted to know if there was a way to record their experiences. M. Ross-Russell said they would most likely have providers who were government funded that were generally unwilling to provide detailed information about their services. S. Anzuman agreed with M. Ross-Russell. She added that hospitals may have their own evaluation process for ER visits. She said they could not ask for ER visit information because they fund HIV care and testing. She said the hospital may have a process for ER visits.

G. Krull-Aquila reviewed goal 1 objective 5 of the QM Plan. She said objective 5 aimed to continue the collaboration between DHH Information Services Unit (ISU) and the EHE team around aligning CQM activities including updating EHE outcomes measures for EHE re-engagement activities. The first action step was to have the QM Plan team meet the EHE team regularly to stay updated on activities and opportunities for QIPs through ISU. The next step was to participate in implementation science training to enhance coordination for EHE activities and explore ways to address provider barriers.

G. Krull-Aquila reviewed goal 2 of the QM Plan. The second goal aimed to improve the coordination between O/AHS and MCM providers to support the linkage and retention of clients in care. The first objective of the second goal aimed to continue to update and share O/AHS

program contact information with MCM providers biannually to support the monitoring of treatment adherence and to improve health outcomes. The first action step was to email O/AHS providers with a contact form to complete. Then they would compile and distribute primary and secondary O/AHS contacts for MCM providers twice a year. The third objective was to create an evaluation process to measure the referral of unsuppressed O/AHS clients to MCM services. The action step to achieve this goal was to evaluate the PHL25 performance measure found in CAREWare.

The fourth objective of goal 2 was to integrate O/AHS and MCM QIPs to foster more collaboration. The action step to complete this objective was communicating and involving both O/AHS and MCM staff during QIP training and discussion. The next action step was to develop an evaluation process for new co-located QIPs. DHH would then present the QM Plan to HIPC to obtain input and feedback. Then DHH would present the QM Plan to the Positive Committee to obtain input and feedback. DHH would explore the feasibility of a biannual check-in with the Positive Committee to receive input and feedback.

G. Krull-Aquila reviewed the third goal. The third goal was to create an inclusive and streamlined QM Plan to guide QM activities. The first objective of this goal was to develop a process to obtain and incorporate consumer feedback into the DHH QM Plan on a regularly scheduled basis. The action step was to coordinate with the DHH Engagement Coordinator to obtain community input and feedback on the QM program and to align efforts with other DHH units.

The second objective of goal 3 was to work with the regional CQM committee of sub-recipients to obtain feedback on the DHH QM plan and amend as needed. The next action step was to gather the needs of each program's regional CQM Committee to obtain input on various QM topics including the QM Plan.

The third objective would connect the provider to the resource they need if they could not provide the training and incorporate their feedback into the QM Plan. The first action step would be to review and update the QM Plan and work plan on a quarterly basis at the ISU QM team meeting. The next step would be to obtain input and feedback from the Leadership team on the QM Plan and workplan. DHH would explore an opportunity to present QM Plan including at the DHH all-staff meeting to get input and feedback.

G. Krull-Aquila reviewed goal 4 of the QM Plan. Goal 4 stated that DHH planned to increase capacity building among programs to support quality management activities. Their first objective for this goal was to create and offer innovative training for providers to enhance their quality management skills. The first action step was to develop online training modules for providers in CAREWare 6. DHH would continue discussions regarding CAREWare centralization on the State server with relevant stakeholders. They would then develop new trainings and provide technical assistance resources for subrecipients on the QI coaching model, Lean Six Sigma, and other relevant QI methodologies.

K. Carter asked how they knew the persons taking the training had comprehended and absorbed the information. G. Krull-Aquila said that the training modules were meant to be supplemental and were meant to act as a refresher. She said some people were visual learners and did not learn well from reading a manual, so this would help cement the information.

S. Anzuman said that CAREWare was their database and that not everyone in DHH could access it. She said that the database would only be helpful to a few people who were dealing with CAREware in the program department.

The next action step in goal 4 was to explore the feasibility of Lunch and Learn type training to subrecipients on various QM topics. G. Krull-Aquila continued to objective 2 of goal 4. The second objective focused on establishing and helping organize a peer-sharing network for programs where people could learn from each other's QI work. The action step for this objective was to compile and confirm a list of programs interested in participating in the network. The next step was distributing contact information and QIP topics to interested participants.

G. Krull-Aquila asked the committee to consider the three questions she had given them in the HIPC meeting. The three questions were:

1. Are there gaps in our plan?
2. What are some of the most important concerns of our consumers from a quality point of view?
3. Are there aspects of quality we should be looking at but aren't?

G. Grannan said in the previous HIPC meeting on March 9, 2023, he had asked a question about a non-criminalized person vs a criminalized person's ability to access care. He was told by the person presenting then that they would investigate the issue. G. Grannan said that even a non-criminalized person would be affected by the issues that a criminalized individual would be facing depending on other factors in their lives. G. Grannan said they should get input from the people facing these issues. S. Aznuman asked him if he was talking about HIV criminalization or general criminalization. G. Grannan clarified that he was speaking about both. He added that he was also speaking about people who were using drugs and those engaged in sex work. He said the QM Plan lacked representation of this small but significant population. S. Anzuman thanked G. Grannan for bringing this to their attention and said it was worth investigating. G. Grannan said they should be aware some people were unwilling to speak to programs and organizations if they feared there was a connection to law enforcement. S. Aznuman agreed that it would be difficult to capture this data.

Discussion Items:

-PA State Plan Concurrence-

M. Ross-Russell reminded the committee they had completed creating the Integrated Plan and that they had a presentation from DHH regarding the goals and objectives. She said that states were required to write a statement of need. She said the statement of need was the same as an Integrated Plan. The EMAs were required to create a preventive care plan. M. Ross-Russell said the question was whether they were going to do a coordination plan with the state or were they going to do an individual plan. M. Ross-Russell said as far as she could remember, Philadelphia had always chosen to do its plan independently. M. Ross-Russell said if there was collaboration at the state level, it was through the health departments. Information to the state would be provided through their HIV planning groups (HPG) or community advisory boards.

M. Ross-Russell said that in this particular instance, they were notified in December 2022 that there was a requirement for a letter of concurrence from HIPC for the state plan. HIPC replied that they did not have any input within the state plan and therefore could not provide a letter of concurrence. She said that a letter of concurrence was not in the Integrated Plan nor the guidelines. She said she would have to provide some support documentation since HIPC had never had to complete a letter of concurrence for the State's Plan–nor had they reviewed or received a presentation on the plan.

G. Grannan asked if they were provided a time frame and if the committee allowed time to review the information before making the letter. M. Ross-Russell said there was no time frame yet. M. Ross-Russell recalled how CPC received a presentation from S. Moletteri comparing the PA State Plan and Philadelphia EMA's Integrated Plan. For the Philadelphia EMA's Integrated Plan, DHH met with HIPC and the other committees 4 times to offer information and collect feedback on the plan. Because of this, HIPC was able to provide concurrence since HIPC members could understand how the Philadelphia Health Department had reached its conclusions. However, in the case of the PA State Plan, M. Ross-Russell they have not received such information/presentations.

M. Ross-Russell said they were meeting next month to discuss the EHE update in April. In May, DHH would be presenting the epidemiological overview from the National HIV Behavioral Surveillance (NHBS). She said they would be preparing for allocations in June. HIPC would most likely have to finalize the allocations for the current year and then prepare for the upcoming year's allocations in July. In August, they would review the allocations process and discuss the decisions regarding each region. M. Ross-Russell said September was the first month they did not have an activity scheduled.

M. Ross-Russell returned to the topic of the letter of concurrence. She said if the State of PA would like the letter, it would need to come from the whole Planning Body. G. Grannan asked if they had to do a meeting and then present it to the council. M. Ross-Russell said potentially yes. She added that the Health Resources and Services Administration (HRSA) needed documentation requiring HIPC to write the letter because the EMA encompassed two states. If it were a requirement for the State of PA, it would most likely be for the State of NJ as well. M. Ross-Russell said they may need a letter of concurrence in NJ.

When the State of PA had told M. Ross-Russell that they were required to write the letter of concurrence, they said HIPC was required due to the guidance. M. Ross-Russell said this would be the case only if the city of Philadelphia had done a joint plan with the state. The PA State Plan was not a joint plan.

M. Ross-Russell said the State of PA most likely believed that they must do a letter of concurrence if the counties included in the EMA represented more than 10% of the state's prevalence numbers. M. Ross-Russell said they had two choices: a letter of concurrence with reservations or a letter of non-concurrence. M. Ross-Russell said she had asked her project officer for documentation supporting the need for the letter of concurrence. There had not been a reply.

The CPC offered their support for M. Ross-Russell and said they had trusted her judgment. G. Grannan asked if they had wanted to ask for information about the letter of concurrence from NJ. P. Gorman said she knew K. Williams from the NJ HPG. P. Gorman said she could contact K. Williams to ask if the State of NJ asked for a letter of concurrence. She added that she had not heard from K. Williams about a letter of concurrence and concluded that it was requested only by the State of PA.

M. Ross-Russell said she had recalled that the State of NJ had approached Dr. K. Brady with a letter of concurrence. Dr. K. Brady said that the state did not have a joint plan with her and she could not provide a letter as a result. The State of NJ rescinded their request.

M. Ross-Russell said that while creating the Integrated Plan, she was on the Philadelphia Planning and NJ Planning committees. K. Carter asked if she was involved in the whole process of creating the NJ State Plan. M. Ross-Russell confirmed that she was. M. Ross-Russell said that the EMA and other organizations in NJ had worked with the State of NJ to create one complete plan. M. Ross-Russell said that if the State of NJ had asked during the process for information, they would have received it since it was a joint process. M. Ross-Russell said that information was also provided to the State of PA. She said they had provided the goals, objectives, and activities forwarded to the Planning Council. The States of NJ and PA provided their goals and objectives.

M. Ross-Russell summarized that they were waiting for the support documentation before they released a letter of concurrence. G. Grannan said they should say they were unwilling to alter their concurrence procedure. K. Carter asked if they needed to bring this issue to the full Planning Council. G. Grannan said they did not have to because they were not changing anything.

-Co-chair Nominations-

S. Moletteri said G. Grannan had been the sole chair for the CPC for some time. She said that due to time constraints, there was no time to discuss the nomination for a co-chair.

K. Carter asked P. Gorman and G. Keys if they wanted the position. S. Moletteri said there may be people who could not attend the meeting who would like the position. M. Ross-Russell asked the committee if they would like to table the discussion until the next meeting. S. Moletteri said she would accept nomination requests right now and via email so they could vote on the next meeting. Then she would contact the nominees to see if they were interested.

Other Business:
None.

Announcements:
K. Carter said he worked with the health department on March 27, 2023. They needed 20 people for a focus group to gather consumer feedback. He encouraged all interested to contact him so he could add them to the list. He said the time would be from 6 p.m. to 7:30 p.m. He said food would be provided and travel expenses would be compensated with the Septa one pass card.

Adjournment:
G. Grannan called for a motion to adjourn. **Motion:** K. Carter motioned, and P. Gorman seconded to adjourn the Comprehensive Planning Committee meeting. **Motion passed:** Meeting adjourned at 3:39 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- March 2023 Meeting Agenda
- February 2023 Meeting Minutes
- PA Integrated Prevention Care Plan 2022-2026 (PDF)