Comprehensive Planning Committee
Meeting Minutes of
Thursday, June 15th, 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, Debra Dalessandro (Co-chair), Pamela Gorman, Clint Steib, Laura Silverman, Adam Williams

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

Call to Order: C. Steib called the meeting to order at 2:04 pm.

Introductions: C. Steib asked everyone to introduce themselves.

Approval of Agenda:
C. Steib referred to the June 2023 CPC agenda and asked for a motion to approve. **Motion:** P. Gorman; C. Steib seconded to approve the June 2023 Comprehensive Planning Committee agenda via a Zoom poll **Motion passed:** 2 in favor. The June 2023 CPC Committee agenda was approved.

Approval of Minutes (*May 24, 2023*):
C. Steib referred to the May 2023 Comprehensive Planning Committee minutes. T. Dominique said she was listed twice as present in the minutes. **Motion:** P. Gorman motioned; K. Carter seconded to approve the amended May 2023 Comprehensive Planning Committee meeting minutes via a Zoom poll. **Motion passed:** 3 in favor, 1 abstaining. The amended May 2023 Comprehensive Planning Committee Minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
M. Ross-Russell mentioned a question that had been raised in a previous meeting concerning the impact of telehealth on provisional medical care units and whether it could influence the upcoming allocation meetings. She explained that they were still awaiting responses from various states to provide an answer. In the meantime, they examined data from the National Institute of Health (NIH) and found a significant 776% increase in telehealth usage nationwide due to the pandemic.

M. Ross-Russell addressed the possibility of employing telehealth for mental health services and any potential changes in licensing. She stated that certain requirements in Pennsylvania had

indeed undergone alterations. She also responded to an inquiry that had been brought up during the preceding Finance Committee meeting. The Finance Committee had sought clarification on why transportation services seemed to have been underutilized. M. Ross-Russell confirmed their suspicion that transportation services in New Jersey had exhausted their funding early in the year and required carryover funding. Consequently, New Jersey was projected to have underspending following the infusion of carryover funds.

M. Ross-Russell clarified that her report aimed to enhance everyone's comprehension of the subjects and the current state of affairs discussed in the subcommittee meetings. She assured the group that she would be available to address any queries as the HIV Integrated Planning Council (HIPC) progressed toward the allocation meetings.

Discussion Items:

–HRSA Data Warehouse Review–
S. Moletteri announced her intention to present information utilizing the Health Resources and Services Administration data warehouse in preparation for the forthcoming allocation meetings. She explained that the focus would be on reviewing data related to primary care and mental health services in each county, aiming to highlight areas with underserved needs. She assured the members that a link to the data would be provided at the end of the presentation, encouraging them to explore it in their free time, as the presentation wouldn't cover all the details.

Commencing the presentation, S. Moletteri outlined the plan to analyze Federally Qualified Health Centers (FQHC) and comparable facilities by county. This would be followed by an examination of the Index of Medically Underservice (IMU) score, which concentrated on primary care data. Finally, the Health Professional Shortage Areas (HPSAs) would be discussed, focusing on Primary Care and Mental Health Shortages. She promised to provide further explanation of the IMU and HPSAs.

S. Moletteri detailed the prerequisites that health centers must meet to qualify as FQHCs. They must provide primary care to underserved populations, offer a sliding fee scale, furnish comprehensive services, maintain an ongoing quality assurance program, and have a board of directors.

In 2021, Philadelphia had 95 FQHCs, while Bucks County had none. Chester County had 7, Delaware County had 5, and Montgomery County had 3. K. Carter inquired about the definition of "FQHC look-alike." D. Dalessandro clarified that it was a distinct category applicable to certain health centers, elucidating the distinctions between FQHCs and FQHC look-alikes. She explained that FQHCs had specific guidelines, including a community advisory board with a designated patient percentage and a board of 30 members. FQHC look-alikes were staffed by civil servants governed by their own personnel rules. In Philadelphia, only the city health centers were FQHC look-alikes, with all other health centers being FQHCs. A. Williams added that at least one city health center had transitioned into becoming an FQHC, naming it Health Center #3.

New Jersey had a total of 19 FQHCs across its counties: four in Burlington County, fourteen in Camden County, four in Gloucester County, and one in Salem County.

S. Moletteri then introduced the concept of the IMU as a grading system to determine underserved areas. A score of over 62 indicated that an area wasn't medically underserved. The criteria considered the provider-to-population ratio, the percentage of the population below the federal poverty level, the percentage of the population aged 65 and over, and the infant mortality rate. The IMU survey was conducted twice a year, in June and December.

Each region received a score based on primary care data. Philadelphia and University City scored 43.3, while the West Park and Market areas also scored 43.3. S. Moletteri highlighted that Bucks County was an exception due to its governor's exception status. Bucks County failed to meet the criteria for a Medically Underserved Area (MUA), with a score exceeding 62. Warminster was the only area in Bucks County considered an MUA with a score of 0. Chester County's two areas scored 61.5 and 54.6. Delaware County scored 55.8, and Montgomery County scored 58.7 and 61.9 in its two areas.

Turning to New Jersey, Burlington County was another governor's exception, mirroring the situation in Bucks County. Camden County scored 48.8, Gloucester County scored 59.2, and Montgomery County, NJ scored 57.1.

S. Moletteri then delved into Philadelphia's Health Provider Shortage Area (HPSA) data, areas where health services were lacking. She presented data for both primary care and mental health services. The HPSA criteria differed from the IMU and included factors such as the population-to-provider ratio, the percentage of people below the federal poverty level, and the average distance to the nearest provider. In primary care, 213 areas were designated as HPSAs, with 71 having a shortage of full-time healthcare practitioners. The average number of practitioners per location was 4, with some locations having higher ratios. In mental health care, Philadelphia had 82 designated HPSA locations.

S. Moletteri proceeded to discuss HPSA primary care data for PA counties. While Bucks County lacked primary care information, Chester County had 20 locations listed as HPSAs. In Delaware County, 39 locations were listed, with a shortage averaging 2.96. Montgomery County had one HPSA location with a score of 2.17.

She then addressed HPSA mental health care data. Bucks County had 2 HPSA locations, both without reported shortages. Chester County had 2 listed locations, while Delaware County had 2 locations, one with a shortage of 0.15. In Montgomery County, one location had a shortage of 3.76 practitioners.

Moving on to New Jersey counties, Burlington County had 3 HPSA locations, with 1.7 practitioner shortages indicated. Camden County had 20 locations, Gloucester County had no reported information, and Salem County had 5 locations with a shortage averaging 0.2 practitioners.

S. Moletteri concluded that the issue with mental health care services wasn't a shortage of practitioners, but rather a lack of provider sites to serve the population.

She then displayed a chart depicting HPSA scores for each location by discipline. The chart included facilities and services like primary care, dental health, and mental health. S. Moletteri noted that Philadelphia required more primary care practitioners.

Finally, S. Moletteri shared the link to the data: Data.HRSA.gov/data/download. The website offered comprehensive information on the health workforce, clinical data, training programs, and grants related to substance use disorder programs.

T. Dominique inquired whether the CPC members found the information useful in making decisions for the allocations meetings. K. Carter expressed gratitude to S. Moletteri for the presentation and mentioned needing more time to assess the usefulness of the information. P. Gorman found the presentation's content interesting and remembered that areas with service shortages used to be prioritized for grants, but wasn't sure if this still applied. She was surprised by the lack of mental health practitioner shortages, as she believed there was an unmet demand for such services. She sensed a disconnect between the collected data and the experiences of providers.

K. Carter raised a question about some providers not accepting Medicaid and Medicare, and whether this could have influenced the data. He explained that healthcare acceptance of these insurances determined the services he could access. P. Gorman agreed with K. Carter, emphasizing how insurance acted as a barrier to healthcare. She drew parallels between dental health and mental healthcare, where the type of insurance could hinder access. S. Moletteri thanked K. Carter and P. Gorman for their insights, acknowledging the possible insurance-related barriers and confirming that the staff had been discussing this topic. She directed a question to P. Gorman about her thoughts on mental health services. P. Gorman concurred with S. Moletteri's assessment of the mental healthcare landscape. She noted a demand for mental healthcare services, but appointments were often subject to lengthy waiting periods. P. Gorman believed that focusing on behavioral services, some of which were offered online, could improve the situation. She observed that psychology services and mental healthcare services involving medication prescriptions posed more significant challenges for scheduling.

A. Williams found the presentation informative but pointed out that it didn't cover the population's barriers to care. S. Moletteri agreed with A. Williams, acknowledging the broad scope of the presentation and the absence of detailed coverage of care barriers. K. Carter questioned whether it was appropriate to request more information about data collection methods and the criteria for determining an HPSA. S. Moletteri deemed it appropriate and shared her own questions, mentioning the need to locate the right person knowledgeable about the data.

M. Ross-Russell provided a definition of HPSA, stating it was an area in the US experiencing a shortage of health professionals. She explained that there were three categories of health profession shortages, typically related to primary care, dental care, and mental healthcare. The primary factor in designating an HPSA was the health professionals-to-population ratio. According to federal guidelines, an area needed a population of 3,500 to 1 health professional to

be considered an HPSA. This threshold could be lowered to 3,000 to 1 in cases of unusually high need. M. Ross-Russell clarified that HPSA designations included those proposed for withdrawal and those without data. By statute, HPSAs weren't withdrawn until a federal register notice was published, usually around July 1st each year. She identified the Bureau of Health Workforce through the Health Services Administration and the Department of Health and Human Services (HHS) as the data source. The Department of Labor and Statistics likely played a role in collecting data at different levels based on population size. M. Ross-Russell confirmed that HHS conducted the analysis. She explained that to remove an HPSA designation, an area needed five primary care physicians. If this criterion wasn't met, the area would still be considered an HPSA. The information was presented to provide CPC members insight into barriers faced by individuals seeking services. S. Moletteri thanked M. Ross-Russell for the explanations and asked whether withdrawn areas were still considered underserved even if well-staffed. M. Ross-Russell confirmed this, explaining that withdrawn locations indicated a shortage in staff. She mentioned mapping HPSA locations in Philadelphia and noted the city's numerous HPSAs due to its population of 1.5 million. S. Moletteri inquired about the ratio for mental health services to be designated as an HPSA. M. Ross-Russell thought it was 3000 to 1 but mentioned the need to review sources for a definitive answer.

P. Gorman asked whether the information was sourced from the National Institutes of Health (NIH) for areas of unmet needs. M. Ross-Russell replied that she didn't have the answer, suggesting that NIH might have a different approach to unmet needs. She committed to providing an answer in the future.

–Allocation Recommendation Brainstorm–

S. Moletteri mentioned in the previous meeting during the joint session with the Prevention Committee to brainstorm ideas for the allocations meetings. She reviewed the usual CPC procedures for creating directives to the recipients. She mentioned that HIPC would not need to vote or approve the directives since it was up to each region to decide if they would like to include these ideas in their directive to the recipient.

S. Moletteri explained what a directive to the recipient entailed. She stated that the directive must be about a specific subpopulation or geographic area and how services should be provided. S. Moletteri referred to the previous year's directives to give CPC members an idea of the directives they could use.

The Positive Committee had put forward some recommendations for directives:

1. Investigate capacity and feasibility for funding a new service for seniors living with HIV, such as Home Health Care.
2. Explore possibilities for covering certain necessities for seniors, such as fall protection devices, orthopedic slippers, and depends.

S. Moletteri suggested that they could reach out to the Department of HIV Health (DHH) for more information about the costs of Home Health Care, though the answer might not be available in time for the allocations meetings. She mentioned that items like depends could potentially be covered under food bank funds. She also indicated that they were uncertain about providing fall protection devices and would need to contact DHH for further details. M. Ross-Russell

mentioned sending questions to DHH and checking policy clarification notices for answers. She emphasized the need to determine the costs of the requested items and find providers and funding for the recommended services. She believed that the answers might not be available before the allocations meetings and suggested sending a request to DHH for more information. She mentioned that Home Health Care was supported by Medicaid, though she wasn't sure of the extent of the support. C. Steib reminded the CPC Committee that the Council on Aging offered free services.

K. Carter shared his experience with in home nursing services, noting that even after paying for 36 hours of nursing service, they still had to pay out of pocket because the care needed exceeded 40 hours per week. M. Ross-Russell acknowledged the expense of nursing services and highlighted the need to consider the cost of the service and its priority within the system. K. Carter inquired about providing glasses for seniors, as many needed them to prevent isolation. M. Ross-Russell looked into vision care and found that the Pennsylvania Medicaid plan covered glasses for individuals over 21.

K. Carter asked about supplemental insurance, a topic he learned about from his case manager. S. Moletteri clarified that supplemental insurance provided $100 for over-the-counter drugs. K. Carter suggested making this a directive, but S. Moletteri pointed out that it related to Medicare, not specifically Ryan White. She proposed making people aware of it, though it was more of an insurer issue. T. Dominque added that the Positive Committee had focused on the aging population with HIV, considering the recent Aging Summit at the DoubleTree. S. Moletteri encouraged the committee to email her with questions or ideas, which didn't have to be fully formed; she could help refine them during the allocations meetings. She shared her email address.

P. Gorman brought up news about opioid deaths and proposed including it in the allocations discussions as a directive for more information. S. Moletteri asked if P. Gorman needed more information from a specific region. P. Gorman recalled hearing the news from Philadelphia but couldn't remember the exact source. She felt that attention towards opioid deaths was waning and wondered if they could examine the situation from an HIV-related perspective. M. Ross-Russell checked with the presenter from the previous HIPC meeting, K. McLoyd, who confirmed an increase in opioid overdose deaths. K. McLoyd offered to connect them with individuals who could provide more information on overdose deaths and the HIV community. P. Gorman questioned whether there was an increase in HIV transmissions due to drug use. M. Ross-Russell mentioned needing to contact DHH for this data, as the information they usually received was categorized.

P. Gorman mentioned the rise in drug overdose deaths, irrespective of how the drugs were used, and wondered if there was a similar increase in HIV transmissions related to drug use. D. Dalessandro, from the Substance Use Prevention and Harm Reduction (SUPHR) program, explained their data on drug overdoses but wasn't sure about HIV transmission records. P. Gorman raised concerns about Methamphetamine use in the LGBTQ+ community, as it might be linked to sexual exposure and HIV. D. Dalessandro clarified that it was an association, not direct

transmission. K. Carter highlighted the impact of the opioid epidemic on minority communities. He also mentioned that seniors used drugs and were vulnerable to elder abuse within the drug trade.

C. Steib expressed concern about mothers using drugs and the potential for increased perinatal transmission rates. D. Dalessandro pointed out that recent cases of perinatal transmission involved mothers with drug use and mental health issues. These mothers often faced barriers to care and might feel ashamed about using drugs while pregnant. She explained that they performed HIV tests during labor and administered preventative measures like Zidovudine to the child, though its effectiveness wasn't guaranteed. T. Dominique reminded the committee that K. McLoyd had discussed these issues in the last meeting. D. Dalessandro mentioned the Health Federation's role in providing perinatal care and HIV tests for pregnant women using drugs in Kensington.

S. Moletteri thanked everyone for their input and noted the populations of concern. She confirmed that the discussion would continue during the allocations meetings. A. Williams suggested that the National HIV Behavioral Surveillance (NHBS) could monitor chemsex among men who have sex with men.

Other Business:
None.

Announcements:
K. Carter announced the Philadelphia Reunion Project. He encouraged the committee members to join and to reach out to S. Moletteri if they were interested.

C. Steib reminded the committee that AIDS education month was this month and they could find workshops on the Philadelphia FIGHT website.

Adjournment:
D. Dalessandro called for a motion to adjourn. **Motion:** K. Carter motioned, and C. Steib seconded to adjourn the Comprehensive Planning Committee/Prevention Committee meeting. **Motion passed:** Meeting adjourned at 3:38 pm.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- June 2023 Meeting Agenda
- May 2023 Comprehensive Planning Committee