COMPREHENSIVE PLANNING COMMITTEE

MEETING AGENDA

Thursday, February 21, 2019
2:00 – 4:00PM
Office of HIV Planning 340 N. 12th Street Suite 320
Philadelphia, PA

Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*January 17, 2019*)

Report of Staff
- **April Meeting**

Report of Chair

Discussion Item
- **Priority Setting Process**

Racial Equity Workgroup

Old Business

New Business

Review/Next Steps

Announcements

Adjournment

PLEASE TURN ALL CELL PHONES TO SILENT.

The next meeting of the Comprehensive Planning Committee is ***March 21, 2019 from 2 to 4 pm*** *at 340 N. 12th Street, Suite 320, Philadelphia, PA 19107.* ***Please refer to the Office of HIV Planning calendar of events for committee meetings & updates (www.hivphilly.org). If you require any special assistance, please contact the office at least 5 days in advance.***

Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, January 17, 2019
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Mark Coleman, Dave Gana, Pam Gorman, Gerry Keys, Nicole Miller, Jeanette Murdock, Gail Thomas, Adam Thompson, Terry Flores-Sanchez, Lorrita Wellington

Excused: Katelyn Baron, Tiffany Dominique, Peter Houle, Gloria Taylor, Leroy Way

Absent: La'Seana Jones, Dorothy McBride-Wesley, Joseph Roderick

Guests: Jessica Browne (AACO)

Staff: Nicole Johns, Dustin Fitzpatrick

Call to Order/Moment of Silence/Introductions: A. Thompson called the meeting to order at 2:11 p.m. and read the mission statement. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: D. Gana moved, G. Keys seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*December 20, 2018*): A. Thompson presented the minutes for approval. **Motion**: D. Gana moved, G. Keys seconded to approve the December 20, 2018 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
None.

Report of Staff:
N. Johns introduced the new staff member D. Fitzpatrick. N. Johns stated that for attendance purposes that Committee members can either reach out to her or call D. Fitzpatrick at his extension 105 or email him at dustin@hivphilly.org

Discussion Items:
A. Thompson introduced the discussion items that the Committee were going to discuss for the day. One was framing out the Racial Equity Workgroup that members talked about at the prior meeting and the other was the Priority Setting Process. He stated further that members would be looking at the process from the last time and identifying if there are any changes that the Committee wanted to make. As members brought topics up, he wrote it on the board into different categories.

Racial Equity Workgroup

N. Johns informed the Committee that the Racial Equity Workgroup will be under the jurisdiction of the Committee. She informed the Committee that they are in charge of giving them their work and figuring out how the group is going to be operating and who they want to be on it. N. Johns asked if someone among the Committee would like to take the lead on this new Workgroup.

A. Thompson suggested that the Committee should figure out what they want the Workgroup to be first, and then hopefully entice someone to become the leader. A. Thompson reminded the Committee of the question they brought up previously involving the current culture and climate of our country surrounding equity and inclusion with a specific focus on racial equity on the Planning Council. He asked for members to brainstorm about what aspects of the issue the Workgroup should examine.

A. Thompson brought up Minority AIDS Initiative (MAI) funding and thought it was critical to look at it across the region and how it is being utilized and targeted. A. Thompson informed the Committee that the MAI is a part of the Secretary of Minority AIDS Initiative around health. He also stressed that it is important to look at it because it is a funding stream that is always under threat because individuals question if the money is necessary. A. Thompson stated it is important for the Committee to be able to articulate how they are using the money especially if questions come down from new legislatures. P. Gorman affirmed that this was important and further proposed asking what the basis for funding to particular agencies was.

A. Thompson asked the group for other suggestions to look at. P. Gorman asked if they get the racial breakout of the Planning Council and the percentages of their membership. A. Thompson agreed that it was good to look at the membership. N. Johns added that the Nominations Committee does look at that and that they have to report back to the funders of the Planning Council. N. Johns stated that in general the Planning Council is pretty good at meeting the representation target. N. Johns added that Positive Committee is looking at meaningful involvement of PLWH and stated that they could look at meaningful involvement in underrepresented populations within the Council, like looking into who is in leadership roles. A. Thompson seconded that they should look beyond membership and that they should look make sure that everyone is being fairly represented in the Planning Council structure. N. Johns said that they could bring the Positive Committee's work into the conversation. A. Thompson agreed.

A. Thompson also suggested recruitment and posed the question of whether or not members are going out into the organizations that are serving hard to reach populations and encouraging them to come in. He provided the example of someone involved with the opioid epidemic visiting and how he wanted this individual to be involved more in the discussion. A. Thompson asked if recruitment was targeted. N. Johns said that it has been but it has not been lately. A. Thompson suggested that the Committee could look at recruitment and retention. He suggested that they may have people coming in, but the question is whether or not they stay or is it just intermittent participation.

G. Keys asked if they are just addressing members of the Committees and Planning Council or are they looking at the provider agencies that receive money without the diversity among staff. G. Keys asked further that if their staff is not diverse, how are they addressing the needs of their consumers. N. Johns stated that this is straddling Planning Council purview because they cannot micromanage agencies. She further stated that getting information about staff at the provider/consumer level is not likely to happen, but she thought that the Planning Council could offer resources to address gaps or valued principles. A. Thompson suggested that it could be like giving access to a diversity and inclusion tool that the agencies could use to identify where they may have gaps. A. Thompson commented that getting the information from providers may not be necessary because the Committee could get it from the AETC Workforce Assessment. P. Gorman disclosed that her agency has to provide that information to AACO. She stated that they have a workforce demographic table that breaks down the percentages of the individual's race/ethnicity, disabilities. N. Johns said that they need to get an aggregate way of knowing how minorities are being represented.

G. Keys agreed that they cannot change the make-up of these agencies, but asked that if the staff are all white or if they are all heterosexual, how does the agency address their consumers' needs. She inquired about the trainings these staffs receive and if they are connecting them to the right resources. She said she has a problem when someone who does not share a common identity with her tells her how to live. A. Thompson qualified this as leading to another category which is training and capacity building, such as focusing on what programs are out there, how people are utilizing it, and what is offered and who is offering it. T. Flores-Sanchez stated while it is important for people to see people who are like them on the staff, it is more important how the staff treats the consumer. A. Thompson agreed and categorized it as implicit or explicit bias and how are people possibly judging or discriminating against people in their delivery of service. He stated that it should be its own category, but may relate to training and capacity building as well as at the provider/clinic level. He further stated that there are tools out there to address bias.

M. Coleman brought up access to healthcare. He said that a lot of people do not know where to turn and they are lost. A. Thompson agreed and categorized this as disparity data and asked J. Browne if AACO has this data. She responded they have the data, but she needs to look further into it. A. Thompson sub-categorized M. Coleman's comment as service access and also established the subcategory of outcomes.

A. Thompson asked the Committee members for any more suggestions they have. K. Carter brought up capacity building in relation to the Planning Council specifically. A. Thompson agreed and added it under the training and capacity building category on the board.

P. Gorman asked about the need for this Workgroup and where it came from. N. Johns informed the Committee members that the origin story took place sometime in 2018 and there was a public comment at a Planning Council meeting made where an individual challenged the Planning Council to look at racial equity in the Ryan White system and

cited recent events that happened in the community. C. Terrell, and M. Ross-Russell came to an agreement that it was something that needed to be addressed. The idea of a separate Workgroup to work on it came up because this did not fit neatly into this Committee's work.

A. Thompson asked members what they expect the Workgroup to come out with. He stated that he thought of it as a fact finding Workgroup. His idea is that the Workgroup would look at the five domains and state their key findings and provided an example of the Workgroup saying that they think the Planning Council is diverse and inclusive, but they think there are some gaps in Training and Capacity Building. A. Thompson stated that he sees the Workgroup reporting to the Committee what they found and then the Committee will decide what they need to examine further. He suggested they are not at the point to make recommendations and P. Gorman agreed. She stated that they would need to come up with goals and objectives. P. Gorman affirmed the overall idea of domains. A. Thompson seconded and defined the five domains listed on the board as MAI funding, Planning Council Membership, Provider/Clinic Level, Training and Capacity Building, and Regional Disparities. He suggested that the idea of explicit/implicit bias is interwoven with all of them and P. Gorman agreed. He iterated that from this they are looking at Planning Council, provider, and then region.

A. Thompson restated the five domains for the members. He said that they could suggest the Workgroup look at these five areas and come back with key trends and themes. P. Gorman said another thing they should do is identify the resources available for each of those categories. A. Thompson asked N. Johns if the OHP could provide the data to look through and N. Johns affirmed OHP can. She added that she was confused about how they are looking at disparities. Her notion of disparities is looking at women of color in the communities or disparities along the continuum as examples and was confused by categorization of Regional Disparities. A. Thompson clarified and re-categorized it as Racial Sub Population Disparities. N. Johns agreed that it is important to look at geographical differences because there are differences in resources based on that contributing to racial disparities.

P. Gorman posed whether identifying racial disparities would be another objective for the Workgroup since they would have to segregate the data to find specific disparities. P. Gorman asked about qualitative data in general about access to care and viral suppression. P. Gorman asked J. Browne if AACO had access to disparity data with trends that they are already seeing. J. Browne stated that AACO does. A. Thompson added that critical things do not always show up on the Care Continuum for people.

A. Thompson asked if they had enough to task out. N. Johns suggested they should figure out where to start and prioritize the list. A. Thompson expressed that the most important thing for the Committee to focus on right now is the Planning Council and the racial sub-population disparities. N. Johns asked if the qualitative sources piece is more of a suggestion and A. Thompson affirmed. He stated that people will want to know where information about these disparities is coming from. He suggested that if the data they collect is in opposition of the data they currently have, they need to know the source so

they can prove its validity. P. Gorman said they can use the qualitative data to find possible themes.

A. Thompson asked if anyone had seen anything that examines utilization of a service versus who is expected to utilize it to show possible disparities. P. Gorman said that her agency does a lot of financial/data reports that looks into the number of clients seeking a service and how many clients accessed that service. She clarified that those reports are not broken down by race and ethnicity. A. Thompson brought up the example about stigma associated with mental health in communities of color where the services are being offered, but it is not being accepted as much as it should be. He stated that the point is to start asking the question why does the sub-population with higher incidences have the lowest utilization. J. Browne stated that she could come up with that data. A. Thompson said that they should start triangulating it: who has it, who do they expect to use it and who did. He suggested looking at J. Browne's data could allow the Committee to see what the current climate is like.

A. Thompson asked the Committee if they had anything else and the Committee agreed what they had was sufficient. A. Thompson asked N. Johns how to make it official. N. Johns said that they need to set a date for when the Workgroup reports back, when they are going to start meeting, and parameters about the types of people that should be a part of it. She stated that anyone on Planning Council is welcome, but suggested if the Committee wants to do targeted recruitment they need to think about who they want to see. A. Thompson inquired if stating their objectives and who they want to see this should be brought up at the next Planning Council meeting. He further stated that he cannot see what subcommittee would not want to be a part of this. A. Thompson suggested holding off on setting dates for the Workgroup to meet. He suggested possibly having one in-person meeting and then a virtual distance space for further meetings. N. Johns informed A. Thompson that it is not impossible, but suggested that there needs to be careful thinking about that because it has to be accessible to the community. Ultimately, N. Johns and A. Thompson agreed that they should leave it up to the Workgroup to decide about how they want to meet.

A. Thompson asked the Committee members about a deadline for them to report back P. Gorman said they should not drag it out too long, but make sure they have the necessary resources to start analyzing data and trends.

A. Thompson stated that if they introduce this to the Planning Council on February 14th, then the Workgroup should have their first meeting by March 1st. He said that they need to recruit at the Planning Council meeting and find other people from each of the subcommittees who may be interested. A. Thompson asked how much time they want to give the Workgroup and suggested the summer. P. Gorman seconded the summer deadline. N. Johns said she would not be surprised if they got it done in under 6 months. She informed the members that it should be done before the Allocations meeting and A. Thompson asked if August 1st would work. A. Thompson and N. Johns both agreed on August 1st N. Johns said the Workgroup would be reporting back to the Committee every month. A. Thompson stated that the Workgroup can divide their meetings up by the five

domains listed on the board and address one to two of them in each meeting. J. Browne asked if it would make sense to have AACO there. A. Thompson agreed because if they have questions, it can be addressed right then and there.

A. Thompson asked if they are going to target people who may not be on Planning Council, but may be interested from outside such as Human Rights advocates T. Flores-Sanchez asked if he was referring to organizations or consumers. A. Thompson suggested just thinking about organizations. He further stated that he is trying to figure out if they should go to specific organizations that are service providers or to the community opinion leaders that bring all of the stories for the organization. The Committee agreed OHP should send out an invitation to all AACO sub-recipients and inform them if anyone is interested to contact a specific person leading the Workgroup. A. Thompson suggested even organizations that are not Ryan White funded. G. Thomas said Esperanza would be good to reach out to and A. Thompson agreed because they could bring the Hispanic community to the table. The Committee all agreed that it should be tasked on the Workgroup to invite/recruit members.

A. Thompson asked if anyone in the Committee wants to chair the Workgroup. He then asked N. Johns if anyone outside of the Committee would be interested. N. Johns responded that she does not have an individual in mind, but suggested some of the members that are not currently at the meeting might be interested.

A. Thompson stated that they will lay out what the Workgroup is, the objectives of the Workgroup, the domains, and the timeline expectations and ask for membership to decide amongst themselves who is going to lead. A. Thompson said it would be a great way to get new voices if they are not comfortable speaking in front of Planning Council. T. Flores-Sanchez asked if it would be helpful to invite them to Planning Council first and then see if they are interested. A. Thompson stated that they do not want to confuse Planning Council recruitment with Workgroup participation. He added that it might intimidate people because they may think that it is a huge commitment. He thinks they should recruit them once they are in the door. A. Thompson agreed to present the Workgroup to the Planning Council in February.

Priority Setting Process

A. Thompson asked the members to review the previous process and decide if they want to continue with what they have or change it. N. Johns explained that she gave a short brief from the Planning Council primer about priority setting and resource allocations. A. Thompson gave the members some time to read it through. A. Thompson reconvened the group after a few minutes. G. Thomas asked about specific acronyms HAP and RWHAP. A. Thompson informed her that HAP stands for HIV/AIDS Program and RWHAP stands for Ryan White HIV/AIDS Program.

N. Johns said that they are going to look at the priority setting worksheet and talk about the columns. She reminded the members of the scale from 1 to 8 and the cards they used. She said the conversation today can be about any part of the process but she asked the Committee to specifically explore these factors and how they are considered.

A. Thompson said that the remainder of the time will be discussing the priority setting factors. He asked if there should be changes made or things that are known now that members would like to see put in. He gave the example of the Care Continuum and explained that the assumption was that if a service was provided at more steps on a continuum, then it makes that service more important. He suggested that the members think of the prescription of ART, which is extremely important to PLWH, and notice how it only hits one continuum bar. He asked the members to think about the critical services of people in the continuum and what particular services are people not getting through the Care Continuum.

P. Gorman said that in order to make these decisions they need qualitative data to examine. A. Thompson agreed that they need to figure out how to determine that the disparities are statistically significant. J. Browne said that AACO has the disparity data, but she would need to figure out specifics. P. Gorman said it might be helpful to know the number of clients accessing different services. N. Johns explained utilization data is only available for services that RW funds. A. Thompson suggested to think about utilization in relation to payer source. N. Johns agreed that it was something they could use in addition to other factors. She provided examples such as looking at disparities along continuum, what services might help with that, and then look at utilization to see if that group is having access to that service. A. Thompson said maybe identifying key populations and after some digging, identifying three critical services in each key population.

P. Gorman stated data on how many people are uninsured and have access to health insurance is important to know. A. Thompson asked J. Browne of the number for uninsured. All the members agreed it was pretty low with the general consensus that it is around 15 percent. P. Gorman stated that this was due to enhanced efforts of getting people on Medicaid.

A. Thompson gave the example of information and referral sources being important for everyone in the Diagnosed, Linked to Care, Retained in Care, and Viral Suppression/Prescribed ART categories. He stated that according to the Care Continuum that service is ranked with greater importance since it hits all 4 areas Diagnosed, Linked to Care, Retained in Care, and Viral Suppression/Prescribed ART categories. He then directed members to look at Treatment Adherence and how it only hits the Retained in Care bar and the Viral Suppression/Prescribed ART bar. He iterated with the current process that this service is rated with less importance than referral services. P. Gorman suggested that some of services need to be marked on to the Linked to Care column because of how aggressive treatment is now. The members came to a general consensus that the current Care Continuum factor does not seem to be accurately measuring these services. P. Gorman said so all services are important to people who need them. A. Thompson said that current process is identifying what services are important to the people who get through. He stated that the Committee is more interested in something that weights how critical something is to key sub-populations experiencing disparities measured by the continuum.

P. Gorman said that AACO should have information on what the disparities are for sub-populations and asked J. Browne what observations have they made so far. J. Browne responded definitively that they have data on disparities. A. Thompson wondered if they could have data about how critical something is and expressed an interest in mixed-methods for the disparity category. He identified this as having quantitative data to identify disparities in sub-populations and qualitative data based on Planning Council and experience-witness data to identify critical services to weight them more. He asked the Committee members what they thought. He provided the example that they know that African-American women experience less viral suppression. He stated that they would discuss what three critical services would help address this disparity and improve suppression.

A. Thompson stated that a disparity cannot be weighed unless linked to a service. N. Johns said that this could be the thinking that feeds into the Community Consciousness category. N. Johns stated that she is concerned that it will end up being similar to the Consumer Survey where people will identify all services are very important to them..

A. Thompson suggested they eliminate the Care Continuum and the Committee can take 20 percent and move it into the Community category. The decision would be informed by disparity data. He said their opinions will weigh more but they will inform their opinions with more data. A. Thompson asked members what they thought. P. Gorman reemphasized that data-driven decision making should weigh heavily because there can be no arguments made against the data.

A. Thompson asked N. Johns what her specific concerns were over Consumer Survey factor. N. Johns referenced the handout with red font and the Consumer Survey Question 38. It asked for survey takers to review a list of services below and check all the services that they used in the last 12 months and the services that they needed, but could not get for any reason. N. Johns stated that there was no way for people to check that they did not need it and people did not necessarily answer the question in the way that it reflects their reality. She informed the members that some people checked all services off even if they had mentioned that they utilized some of the services. She explained that because the Consumer Survey did not match up with the utilization data that they had, that she would not base 25 percent of their decision on it. N. Johns suggested that there are still some things to consider from the Consumer Survey. She stated that they could distill the survey into important key trends and themes to consider. She gave the example that some people noted specific barriers such as living in poverty or not having housing and a percent table would not really capture this. P. Gorman asked when is another survey going to be done and N. Johns responded that it comes out every four to five years. A. Thompson agreed with N. Johns' suggestion. .

A. Thompson stated if they cut the 25 percent from the Consumer Survey, then they could throw 10 or 15 percent into the Unmet need bucket and the other 10 percent in the Community need bucket. A. Thompson asked if they could make it weigh less, but keep the question. He suggested moving more weight to the unmet need category. N. Johns

clarified she heard that Consumer Survey should be 10 percent and then move the remaining weight over to the Unmet Need category. P. Gorman agreed it was a good idea because consumer data is not changing and it may not match up with what today looks like. P. Gorman asked if the survey still its own factor. A. Thompson agreed and clarified they are redistributing the weight.

A Committee member asked what exactly Unmet Need meant and N. Johns clarified that in the Consumer Survey, Unmet Need means that someone needed a service, but could not get it. A. Thompson suggested that the Unmet Need category be broken up into the two sources that it uses: the Medical Monitoring Project (MMP) and the Client Services Unit (CSU) Intake. A. Thompson suggested removing Care Continuum as a category and taking that 20 percent and moving it over to Community Conscience. He stated that the Consumer Survey could be 10 percent and Essential Health Benefit left at 10 percent. This way the heaviest weight is still placed on the data. A. Thompson suggested renaming Community Conscience and referred to it more as the Committee's stakeholder opinions based in data that they are reviewing. A. Thompson suggested that the conversation should begin with the analysis from the data already there because it would allow them to delve deeper faster.

P. Gorman suggested that under Planning/Community is where they should add the qualitative data and A. Thompson agreed. P. Gorman elaborated that doing this would bring some substance to meeting discussions. A. Thompson suggested to the Committee that this is where they would see what the disparities look like and the information available geographically which is important because people outside the city may not have those services available and it may help determine where funding needs to go. N. Johns reminded the Committee that they are not supposed to talk about money because that is a separate process and instead look at how services varied by region.

A. Thompson wrote the priority setting categories on the board along with how the group wanted to weight them: Consumer Survey should be 10 percent, Essential Health Benefit should be 10 percent, CSU should be 20 percent, MMP should be 20 percent and Planning/Community should be 40 percent. The factors used for the Planning/Community category are quantitative and qualitative data, disparity, geographic, and utilization. A. Thompson suggested mentioned the Goldilocks rule in reference to the data that they collect because too much data may overload people. He said the data tables should be available and asked if they could work with the OHP on this. N. Johns said that they need to think very specifically about the questions in order to figure out whether they can answer the question.

A. Thompson set the agenda for the next meeting which is to flesh it all out and be very clear about how the Planning/Community category should be weighed. He stated that this could also be the place to discuss emerging issues. All Committee members agreed.

Old Business:
None.

New Business:
None.

Next step is at the Planning Council to review the Racial Equity Workgroup membership and recruitment for that.

Announcements:

J. Murdock asked if anyone knew J. DeMarco and informed the members that his cousin passed away and the funeral is January 22nd.

M. Coleman told members to enjoy the holiday.

Adjournment: The meeting was adjourned by general consensus at 3:58 p.m.

Respectfully submitted by,

Dustin Fitzpatrick, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from December 20, 2018
- Priority Setting and Resource Allocations Primer
- Service Priority Setting Worksheet 2017
- Unmet need data for Priority Setting 2017
- Philadelphia EMA Planning Council FY 2017 Priority Setting Tool
- Cascading bar graph of services
- OHP Calendar

Service Priority Setting Worksheet 2019

Each service category will be scored according to these factors and scales using the sources noted for each factor. For the Community Voices factor each individual will vote their conscience and scores will be tallied by the average of those scores.

Factor	Definition	Scale
Consumer Survey (10%)	Percentage of consumers who said they used or "needed but didn't get" in the last 12 months, in the 2017 Consumer Survey.	1- 0-15% 3- 16-30% 5- 31-45% 8- >46%
Medical Monitoring Project (20%)	Medical Monitoring Project data captures unmet service needs for PLWH in care. It is a representative sample of PLWH in HIV care.	1 – no mention 3 – 1-20% 5 – 21-50% 8 – >50%
Client Services Unit-Need at Intake (20%)	Self-reported service need to Client Services MCM intake. These individuals are re-entering or entering the RW service system.	1 – no mention 3 – 1-20% 5 – 21-50% 8 – >50%
Essential Health Benefit (10%)	The Affordable Care Act ensures health plans offered in the individual and small group markets, offer a comprehensive package of items and services, known as *essential health benefits*. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	1 – Yes 5 – Yes, but may not meet PLWHA needs or HIV care guidelines 8 - No
Community Voices (40%)	This factor seeks to quantify community opinion/expertise of delivering and receiving HIV services in relationship to emergent needs and issues, vulnerable populations, community knowledge, and other EMA data.	1- not critical to vulnerable populations or emergent needs at this time. 5- This service is critical for vulnerable populations and emergent needs 8- this service is a current priority need for vulnerable populations and emergent needs

Racial Equity Workgroup Purpose and Scope

Comprehensive Planning Committee January 2019

Membership: Representation from each HIPC committees, AACO, and stakeholders and community leaders from under-represented communities (to be determined by workgroup). Membership of workgroup will be between 10-20 members.

Purpose: To provide key findings and themes to Comprehensive Planning concerning racial equity in the following areas:

- Planning Council Membership/Leadership (current membership, meaningful involvement of most impacted communities, recruitment/retention efforts)
- Provider/Clinic level disparities (workforce, plans for addressing gaps, and resources for supporting equity)
- Funding allocations- particularly Minority AIDS Initiative and Ryan White Part A
- Training & capacity (HIPC and local service providers)
- Racial subpopulations disparities in health outcomes and service access

The workgroup will be provided with data from OHP and AACO to make assessments on the above areas of focus. These quantitative and qualitative data sources may include RW program data, HIV surveillance data, allocations/spending data, utilization data, needs assessment data, other local or national research/data, HIPC membership information, and other relevant reports.

Workgroup will schedule their first meeting by March 1st.

Workgroup will report themes and trends to Comprehensive Planning by August 1st. After this report, the Comprehensive Planning Committee will determine how to proceed and whether the workgroup will continue or dissolve.

Comprehensive Planning will include a standing agenda item for the workgroup to provide updates.

Anyone interested in participating should contact Nicole Johns at 215-574-6760 or nicole@hivphilly.org

Fig. 11: Gaps in Service as Reported by Consumers by Percent			
Service Reported as Needed	**PDPH Client Services Unit Need at Intake (n=1,976)**	**Medical Monitoring Project (n=166)**	**EMA Consumer Survey (n=392)**
Medical Care	26.5	4.2	3.8
Medications	22.1	1.5	3.8
Treatment Adherence	40.9	1.9	9.9
Dental	3.8	45.1	11.2
Home Health Care	1.8	N/A	11.2
Mental Health	21.6	9.7	10.5
Case Management	N/A	15.7	5.9
Substance Abuse Treatment	4.9	2.7	8.7
Food	23.5	6.5	9.9
Housing	50.1	16.0	15.1
Transportation	22.8	12.5	11.2
Support Groups/Peer Support	4.8	8.0	9.4
HIV Education/Risk Reduction	10.1	N/A	N/A
Benefits Assistance	40.2	18.4	11.7
Language Translation	2.0	0.0	10.5
Patient Navigation	N/A	2.3	7.9

Fig. 4: Non-Concurrent and Concurrent HIV/AIDS Among Incident HIV Diagnosis by Race, Gender, Age and Transmission Risk, 2016				
	Concurrent HIV/AIDS		Total HIV Diagnoses	
	N	Row %	N	Col %
Total	152	21.2%	716	100%
Gender				
Male	113	20.6%	553	77.4%
Female	39	25.2%	151	21.4%
Transgender	0	0.0%	12	1.3%
Race/Ethnicity				
Black	90	20.5%	439	60.9%
Hispanic	22	18.3%	120	16.7%
White	36	25.2%	143	20.0%
Other	4	28.6%	14	2.4%
Age Group at HIV Diagnosis				
<13	0	0.0%	1	0.0%
13-24	11	7.5%	48	6.8%
25-29	15	11.5%	110	15.4%
30-39	44	21.0%	131	18.3%
40-49	44	38.7%	210	29.3%
50+	41	37.3%	106	14.8%
Transmission Risk				
Men who have sex with men (MSM)	59	17.0%	347	48.5%
Injection drug use (IDU)	13	24.1%	54	7.5%
MSM/IDU	1	11.1%	9	1.3%
Heterosexual	46	24.6%	187	26.1%
No identified risk	33	28.0%	118	16.5%
Pediatric exposures	0	0.0%	1	0.1%
Geographic Area				
Philadelphia	93	18.8%	496	69.3%
PA Counties	41	35.0%	117	16.3%
NJ Counties	18	17.5%	103	14.4%