Ryan White Planning Council (RWPC) of the Philadelphia Part A EMA
Meeting Minutes
Thursday, April 14, 2016
2:00-4:00p.m.

Present: Tre Alexander, Juan Baez, Michael Cappuccilli, Keith Carter, Karen Coleman, Mark Coleman, Alan Edelstein, Tessa Fox, David Gana, Pamela Gorman, Sharee Heaven, Sayuri Lio, Christine Quimby, Ann Ricksecker, Joseph Roderick, Samuel Romero, Steve Saunders, Nurit Shein, Leroy Way, Deanne Wingate

Excused: Katelyn Baron, Kevin Burns, Cheryl Dennis, Lupe Diaz, Peter Houle, Andrena Ingram, Gerry Keys, Tyler Berl

Absent: Jacob Adeniran, Ralph Bradley, Edward Campbell, Christopher Griddle, Loretta Grimes, Christina Hoegel, Dinita McGee, Craig Street, Adam Thompson, Kyle Tucker, Lorrita Wellington, Melvin White

Guests: Lorett Matus (HPG), Jen Chapman (HPG), Gus Grannan (HPG), Caitlyn Conyngham (HPG), Willie Jenkins, Timothy Benston, Sebastian Branca (AACO), Evelyn Torres (AACO), Ricardo Colon (AACO), Chris Chu (AACO), Eric C

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order: K. Coleman called the meeting to order at 2:11p.m.

Welcome/Introductions/Moment of Silence K. Coleman welcomed RWPC members and guests. Those present then introduced themselves.

Approval of Agenda: K. Coleman presented the agenda for approval. **Motion**: D. Gana moved, K. Carter seconded to approve the agenda. **Motion passed**: All in favor.

Recap of Previous Meeting: K. Coleman reported that at their last meeting the Planning Council approved a reallocation request from the grantee. They also heard standard subcommittee reports.

Approval of Minutes (*March 10, 2016*): K. Coleman presented the minutes for approval. **Motion:** L. Way moved, M. Coleman seconded to approve the March 10, 2016 minutes. **Motion passed**: All in favor.

Report of Co-Chair: J. Chapman noted that the next HPG meeting on April 27th would also be combined with the RWPC. She said she'd give her co-chair report at that meeting.

Report of Staff: M. Ross-Russell noted that there were many upcoming items on the Planning Council and OHP's agenda. She stated that she'd be reviewing an agenda of upcoming events.

M. Ross-Russell stated that this year's grant application would be submitted in August as opposed to October or November (which was the usual due date). She noted that the EMA had not received their notice of grant award for this coming year. She stated that HRSA anticipated releasing the notice of grant award between the 1st and the 15th of May.

M. Ross-Russell explained that the Finance Committee meeting would typically be held the first Thursday of May, and the Planning Council would be held May 12th. She requested that the Finance Committee be moved to May 12th and the Planning Council meeting be moved to May 19th. She requested

that the Comprehensive Planning Committee meeting also be moved to the next week. She stated that the change would allow time for the Finance Committee to review the notice of grant award, and the Planning Council could then vote to approve the allocations for FY2016.

M. Ross-Russell explained that some funding shifts that were required by HRSA's Policy Clarification Notice 16-02 would be made in the allocations process. She explained that the allocations for 2017 needed to be done after the notice of the 2016 grant award was received. She said some tentative dates had been chosen for allocations meetings, which would have to be held in June. She stated that the OHP calendar would be updated with the tentative dates (June 14th, June 16th, and either June 21st or 23rd). She stated that a Finance Committee meeting would need to be held in July, and the Finance Committee and Planning Council would vote on the Part A and Minority AIDS Initiative (MAI) allocations at their July meetings.

M. Ross-Russell reported that the CDC grant application would be due in late August or early September. She added that the Integrated Care and Prevention Plan was due sometime in September. She stated that the OHP Consumer Survey process would be beginning at some point in September. She explained that the Consumer Survey needed to be done to allow for Priority Setting next year. She noted that Policy Clarification Notice 16-02 would affect the service priorities, as it removed some service categories and changed the definition of others. She stated that new data was available that would be used for the Priority Setting process.

M. Ross-Russell noted that some other upcoming agenda items included the annual OHP epidemiologic profile and the resource inventory. She reported that the OHP would be moving to a new location, on the 3rd floor of the Wolf building. She said the move was planned for the next 2 weeks. She stated that the Planning Council and HPG would be kept abreast of all developments. She asked the group to ensure their emails were current so they'd be able to receive important communications.

M. Ross-Russell added that Nicole Johns' report on the high-risk heterosexual focus groups was available on the OHP website, and copies had been placed on the side table.

E.C. asked for more information about the CDC grant application. M. Ross-Russell replied that the CDC provided Philadelphia with HIV prevention dollars. She stated that the HIV Prevention Planning Group (HPG) reviewed the prevention plan and submitted a letter of concurrence, concurrence with reservations, or non-concurrence with the application.

K. Coleman encouraged Planning Council members to fully participate in the upcoming planning processes. T. Alexander invited everyone to attend the meetings of any subcommittees that interested them.

M. Ross-Russell added that the Comprehensive Planning Committee and Needs Assessment Committee would be participating in joint meetings leading up to the consumer survey.

Public Comment: None.

Special Presentation:

- **AACO Client Services Unit (CSU) Report –** *Sebastian Branca and Evelyn Torres, AACO*

Medical case management (MCM) Services in the Philadelphia EMA & AACO CSU data/activities – E. Torres

E. Torres stated that the Philadelphia EMA had achieved an 82% viral suppression rate, which surpassed the National HIV/AIDS Strategy (NHAS) goal of 80%.

E. Torres began by presenting slides on Medical Case Management (MCM). She noted that the delivery of medical case management (MCM) services in the EMA had changed a great deal over the years. She noted that HRSA provided funding for the EMA under the Ryan White Act. She explained that the majority of medical case management dollars for HIV/AIDS came from this program. She reported that HRSA had recently released Policy Clarification Notice 16-02, which laid out allowable uses of Ryan White funding. She stated that it would take effect in 2017. She provided the most recent HRSA definition of medical case management, "The provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum."

E. Torres noted that there was a prescribed set of activities that MCM provided. She said these included assessing clients' needs, planning for their medical care, coordinating health and support services, monitoring clients, periodically reviewing their needs and care plan, providing counseling for treatment adherence, and providing advocacy as necessary. She explained that HRSA had made a clear distinction between medical and non-medical case management. She pointed out that MCM had, as its objective, improving health outcomes. Non-medical case management, on the other hand, had the goal of "providing guidance and assisting in improving access to needed services." She noted that non-medical case managers assisted clients to access transportation, emergency funds, housing, and other needs.

K. Coleman asked if Ryan White Part A funding would be provided for the category of Non-Medical case management. E. Torres stated that the Planning Council would make allocations decisions for funding the service categories. However, she added that Medical Case Managers in Philadelphia were already fulfilling many of the functions of Non-Medical Case Managers, as well as addressing medical issues.

E. Torres stated that $8.6 million was currently allocated to MCM in the EMA under Ryan White Part A/B and Minority AIDS Initiative (MAI) funding. She stated that 8,856 unduplicated clients received MCM services in 2014 through Ryan White Parts A-D for AACO funded agencies. E. Torres reported that AACO's Client Services Unit (CSU) did 2,015 intakes in 2015. She added that AACO funded 21 providers in the EMA. She noted that 147 MCMs were funded in the system was well as 35 supervisors. She said that over 14,000 clients had been served by Outpatient Ambulatory Medical Care through Ryan White, which amounted to more than half of PLWHA in the Philadelphia area.

E. Torres shared a slide showing the HIV Care Continuum. She said Ryan White services had been plotted along the graph to show which points of the Continuum they impacted.

A. Ricksecker stated that the Comprehensive Planning Committee had recently discussed the service category of Treatment Adherence. She asked if Medical Case Managers were providing Treatment Adherence counseling. E. Torres said they were. A. Ricksecker asked if there was any funding for separate Treatment Adherence counselors. E. Torres replied that the Treatment Adherence service category had not been funded in many years. R. Colon noted that Treatment Adherence was no longer allowable as a discrete service category, per 16-02.

E. Torres stated that the AACO CSU aimed to "help HIV infected and at-risk individuals understand their needs and make informed decisions about possible solutions." She said the CSU was responsible for providing intake services to HIV positive individuals requesting MCM, providing information and referral services for all other AACO funded programs, processing individuals' requests for Housing Opportunities for People with AIDS (HOPWA) and Shelter Plus Care (SPC) housing subsidies, taking feedback about funded providers, and running the Local Case Management Coordination Project.

E. Torres stated that the AACO Health Information Helpline was open from 8am-5:30pm from Monday through Friday[1]. She added that helpline staff members spoke Spanish and that interpretation for other languages was available.

E. Torres reported that there were currently 33 people on the CSU Case Management waiting list. She said that people with emergencies were immediately referred to MCM providers. She added that CSU workers facilitated HIV medical appointments for all clients reporting no HIV medical care in the last 6 months.

E. Torres reviewed demographics for CSU intakes (*see slides*). E. Torres noted that Philadelphia had many people in deep poverty. D. Wingate asked why there were so few people with Veterans Affairs (VA) or other military insurance in the pie chart. E. Torres replied that the percentage only included people who were insured under military programs, and it did not encompass all veterans. She added that Ryan White was a payer of last resort. Therefore, veterans who had access to the VA system may be referred back to it before accessing Ryan White services. R. Colon noted that AACO was responsible for ensuring that there were no barriers to veterans accessing Ryan White services.

E. Torres pointed the group to the chart of client needs, as reported at the point of intake. She noted that, aside from Medical case management, a majority of clients were looking for Benefits Assistance or Housing. She explained that most clients who were calling the helpline were already in medical care. D. Wingate asked why there were many African Americans looking to access Ryan White services. E. Torres explained that a majority of PLWHA in the EMA were African American. E. Torres stated that many new infections were concentrated in young Black MSM. T. Alexander asked if clients had trouble getting care because they lacked IDs. E. Torres noted that case managers were trained to help clients get IDs. She agreed that a lack of ID could act as a barrier to care.

E. Torres reviewed a slide funding for AACO's Housing Services Program (HSP). She explained that the program received no Ryan White funding, and was 100% funded by the Philadelphia Office of Housing and Community Development (OHCD). She reminded the group that Ryan White prohibited funding permanent housing programs. D. Wingate asked where OHCD got its funds. E. Torres stated that they received funding from the Federal Government and Housing and Urban Development (HUD). She added that housing was also provided through HOPWA and Shelter Plus housing programs. A community member noted that he was on the waiting list for HOPWA. E. Torres explained that there was currently a 7 year waiting list for the program. She stated that housing was a limited resource in Philadelphia.

E. Torres explained that HSP provided a centralized intake for applicants seeking permanent rental assistance. She stated that the main referral source for housing sponsors providing HOPWA or Shelter + Care Housing. She noted that there was a waiting list for HOPWA and Shelter + Care due to the small number of available housing slots in Philadelphia. She explained that people who were homeless had priority on the HOPWA waiting list. She added that people who were chronically homeless had even higher priority. She stated that 376 applicants were currently on the waiting list as of 4/12/16. She noted that homeless individuals had a wait time of 18 months or more, whereas other applicants had a wait time of 7 years or more. She stated that homelessness had to be verified for a shorter wait time.

E. Torres noted that all AACO funded providers were required to have a grievance process. She stated that MCM services had to share the process with their clients. She noted that clients had the option of calling the Health Information Helpline with their feedback. She added that the Helpline handled all DEFA appeals.

[1] 800/215-985-2437

K. Carter asked what the cost was to get one person into housing. S. Heaven said the cost was about $10,000 per year.

Quality Management and MCM Services – S. Branca
S. Branca explained that the quality management process included quality assurance, outcomes monitoring and evaluation, and continuous quality improvement, with the goal of using data to improve access to quality HIV care. He said that site visits and checking records were both parts of the process of making sure sites were performing up to standards. He pointed out that the quality improvement process also helped ensure that the system would work better in the future.

S. Branca reviewed the National HIV/AIDS Strategy (NHAS) goals[2]. He said that the performance measures, quality management programs, and CSU priorities were all aligned with NHAS. He added that the HIV Care Continuum was closely tied to the NHAS goals. He explained that a variety of quality improvement projects were currently directed at different areas of the continuum. He stated that many prevention programs targeted diagnosis and linkage to care. He added that, on the care side, the goal was retention in care and viral suppression. He noted that performance measure portfolios were updated in 2014 to focus on the continuum of care.

S. Branca stated that AACO annually reviewed performance data from providers and provided feedback based on the data. He noted that Philadelphia was a data-centered EMA, and data was used to improve medical outcomes. He stated that providers were asked to use data to figure out how they could use their resources to address problems with service delivery. He added that organizations were given a ranking to show how they were doing relative to other organizations in the system. He explained that the reports were used to formulate Quality Improvement Projects (QIPs) and Technical Assistance (TA). He explained that there were also regional QI meetings. He stated that technical assistance was deployed when providers needed help to meet benchmarks.

S. Branca stated that outcomes were monitored in the EMA through performance measures. He stated that appointment availability was also used as a system measure. He explained that AACO called providers to see how long it took to get appointments. He said this calling process was used to identify barriers to care for Ryan White clients. He noted that, after AACO followed up on any problems, 85% of the providers had cleared up those problems prior to reevaluation. Finally, he explained that outcome monitoring included disparities in care. He stated that the data was evaluated to see if health outcomes varied by insurance status, race, etc. He noted that data analysis was anonymous.

S. Branca stated that the CSU looked at 23 performance measures for medical services, 7 for MCM measures, and 3 for oral health measures. He noted that measures for other services were collected through the PDE (a combined data set).

S. Branca reviewed the 7 MCM measures. He noted that medication and counseling and prescription of antiretroviral therapy were local measures. He said that the last 3 measures were national standards. He read off statistics of area performance on MCM performance measures. He noted that performance on several of the measures had improved between 2014 and 2015. E. Torres pointed out that clients who were in case management were typically in medical care. S. Branca added that the performance measures were highly correlated with the HIV Care Continuum.

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[2] (1) Reduce New Infections, (2) Increase Access to Care and Improve Health Outcomes for People Living with HIV, (3) Reduce HIV-Related Health Disparities and Health Inequities, (4) Achieve a More Coordinated National Response to the HIV Epidemic

S. Branca noted that the CSU placed a heavy emphasis on feedback. He stated that data visualization was critical in getting the attention of program leadership. S. Branca gave a sample of a performance feedback report that Medical case management programs would receive from AACO. He noted that color coding made it easy for providers to understand the feedback.

S. Branca stated that Quality Improvement Projects (QIPs) were expanded to MCM in 2012. He said that the grantee provided feedback to providers on all plans and required revisions as needed. He noted that AACO provided quarterly updates on the QIPs. He stated that AACO had defined key measures and set automatic thresholds to make sure they were getting a reasonable return on their investment in various programs. He said that programs may still select other measures for improvement in addition to any required QIPs. He asserted that the QIPs were very effective and generally helped providers improve their service delivery.

S. Branca stated that the PDPH emphasized consumer participation in the quality improvement process. He noted that consumers served on QI teams or committees and gave input during key stages of QI processes. He stated that the PDPH held consumer focus groups and conducted client surveys to get input about low performance or proposed action steps. He added that MCM programs had been particularly effective at incorporating consumers into QI.

G. Grannan noted that one of the core measures was a gap measure, which gauged time between medical visits. He noted that the populations he worked with were prone to falling out of the care system because of incarceration, substance use treatment, etc. He stated that these individuals would appear to be out of care, but weren't necessarily. He asked if AACO could follow up on these individuals and tell if they were out of care. E. Torres stated that the gap measure was about holding the provider accountable. G. Grannan noted that some providers were unable to follow-up on various clients. E. Torres stated that AACO surveillance was starting to do work with the Philadelphia Prison system to track diagnosis and treatment along the HIV Care Continuum. S. Branca added that providers were participating in a new program called START Care, where they were able to check their out-of-care lists against other providers'. E. Torres stated that the program was lowering the number of clients who were listed as out of care by any given provider. G. Grannan reiterated that some clients were impossible to track. S. Branca agreed. He explained that the gap measure used combined data from all providers. He stated that some of the data was duplicated across numerous providers, but it was unduplicated through the PDE, which reduced the number of patients who were recorded as out of care by about 10%. He noted that the EMA was close to the NHAS goal of 90% in care.

K. Coleman noted that some virally suppressed medically stable patients were not showing up to appointments every 6 months. S. Branca said this idea (that some stable patients stopped showing up for regular appointments) was not supported by data on the population level. He noted that clients who were not virally suppressed tended to go to 4 medical appointments a year whereas clients who were virally suppressed went to an average of 5 appointments. He said some case management agencies brought up K. Coleman's point when explaining high numbers on the gap measure. S. Branca stated that AACO requested that providers give data to back up these ideas, and many could not. E. Torres explained that AACO tried to be fair and understanding to providers. T. Alexander asked if data would be collected for people who were incarcerated but continued to see their case managers. S. Branca said it would. However, E. Torres pointed out that people who were in long-term incarceration did not have medical case managers, particularly people at state institutions, who were incarcerated for 2 years or more. However, she pointed out that the longest stay at the Philadelphia jails was a year, and sometimes less. She stated that Ryan White services were provided to some of these individuals.

K. Carter asked if providers should be seeing patients more often than every 6 months, considering that they needed to recertify clients every 6 months. S. Branca agreed that clients should be visiting their

doctors more often than once every 6 months. K. Carter asked if involving consumers in the QI process could compromise confidentiality. S. Branca said there were safeguards against violations of HIPAA requirements.

Finance Committee – *A. Edelstein, Co-Chair*
No report. T. Alexander reiterated that the Finance Committee would meet on May 12th from 2-4pm.

Needs Assessment – *G. Keys, Co-Chair*
M. Ross-Russell stated that the Needs Assessment Committee oversaw the distribution of a transportation survey to providers. She said the survey had been sent out through SurveyMonkey to AACO's case management listserv. She reported that the Needs Assessment Committee had reviewed the results of the survey. She stated that the providers gave feedback on transportation and barriers to it. She noted that some common barriers that were mentioned included day passes, Logisticare, and SEPTA tokens.

Comprehensive Planning Committee – *L. Diaz, Co-Chair*
N. Johns stated that the CPC had reviewed 2014 data on the insurance status of Ryan White clients. She explained that the group was exploring a Health Insurance Premium/Cost-Sharing Assistance Program. She said they'd continue the conversation when they received 2015 insurance data. She added that the CPC discussed structural interventions and issues with housing. She stated that they would continue discussing Health Insurance Premium Cost-Sharing Assistance along with the high risk heterosexual focus group report next month.

Positive Committee – *K. Carter, Co-Chair*
K. Carter stated that the LGBT Elder Initiative (LGBTEI) had held a meeting in the OHP's space last month, in lieu of a Positive Committee meeting. He said the event was successful and around 20 people attended. He invited all participants to attend the next Positive Committee meeting on May 9th.

Nominations Committee – *M. Cappuccilli, Co-Chair*
M. Cappuccilli stated that the Nominations Committee had met last month and reviewed Planning Council applications. He said they had accepted 4 new members and 4 returning members to the Planning Council.

Old Business: None.

New Business: None.

Announcements: M. Coleman stated that April is Jazz Month in Philadelphia.

J. Chapman reminded the group that Kathleen Brady from AACO would be giving her annual Epidemiologic Update on April 27th from 2:30-4:30pm, during the HPG meeting slot. M. Ross-Russell strongly recommended that all RWPC and HPG members attend the meeting.

T. Alexander stated that AIDS Education Month was in June.

T. Fox reported that the annual Dining Out for Life event was happening today in Philadelphia. She said various restaurants were donating parts of their proceeds to ActionAIDS. She stated that a list of participating restaurants could be found at http://www.diningoutforlife.com/philadelphia.

Adjournment: **Motion**: M. Cappuccilli made, D. Gana seconded a motion to adjourn the meeting at 3:47p.m. **Motion passed**: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- March 10, 2016 Meeting Minutes
- January 2015-December 2015 Outpatient/Ambulatory Medical Care Quality Management Data
- OHP Calendar

Meeting Agenda

Thursday, April 14, 2016
2:00 p.m. – 4:00 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Recap of Previous Meeting
- The Planning Council approved a reallocation request from the grantee. They also heard standard committee reports.

Approval of Minutes (*March 10, 2016*)

Report of Co-Chairs

Report of Staff

Public Comment

Special Presentation
- Client Services Unit (CSU) Report – *Sebastian Branca and Evelyn Torres (AACO)*

Report of Committees:
- Finance Committee—Alan Edelstein, Co-Chair
- Needs Assessment Committee— Gerry Keys, Co-Chair
- Comprehensive Planning Committee—Lupe Diaz & Katelyn Baron, Co-Chairs
- Positive Committee—Keith Carter, Co-Chair
- Nominations Committee—Michael Cappuccilli, Co-Chair

Old Business

New Business

Announcements

Adjournment

Ryan White Planning Council (RWPC)

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

The next Ryan White Planning Council (RWPC) meeting is scheduled for
Thursday, May 12, 2016 from 2:00 – 4:00 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 203, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Ryan White Planning Council (RWPC) of the Philadelphia Part A EMA
Meeting Minutes
Thursday, March 10, 2016
2:00-4:00p.m.

Present: Tre Alexander, Juan Baez, Katelyn Baron, Ralph Bradley, Kevin Burns, Michael Cappuccilli, Edward Campbell, Keith Carter, Karen Coleman, Mark Coleman, Cheryl Dennis, Lupe Diaz, Alan Edelstein, David Gana, Pamela Gorman, Sharee Heaven, Gerry Keys, Sayuri Lio, Joseph Roderick, Nurit Shein, Adam Thompson, Gary Tumolo, Leroy Way, Lorrita Wellington

Excused: Peter Houle, Andrena Ingram, Samuel Romero

Absent: Jacob Adeniran, Christopher Griddle, Loretta Grimes, Christina Hoegel, Dinita McGee, Ann Ricksecker, Craig Street, Kyle Tucker, Melvin White, Deanne Wingate

Guests: Bikim Brow, Fran Brzyski, Laura Martindale, Evette M Colon-Street, Terry Smith Flores, Chris Chu (AACO), Ricardo Colon (AACO), Jamie Stevenson, Timothy Benston

Staff: Mari Ross-Russell, Nicole Johns, Jennifer Hayes

Call to Order: K. Coleman called the meeting to order at 2:05p.m.

Welcome/Introductions/Moment of Silence K. Coleman welcomed RWPC members and guests. Those present then introduced themselves.

Approval of Agenda: K. Coleman presented the agenda for approval. **Motion**: G. Tumolo moved, L. Way seconded to approve the agenda. **Motion passed**: All in favor.

Recap of Previous Meeting: K. Coleman reported that at their last meeting the Planning Council approved a reallocation request and a level funding budget for the 2016-2017 fiscal year. The Planning Council also heard standard committee reports.

Approval of Minutes (*February 11, 2016*): K. Coleman presented the minutes for approval. **Motion:** G. Keys moved, L. Way seconded to approve the February 11, 2016 minutes. **Motion passed**: All in favor.

Report of Co-Chair: T. Alexander thanked Planning Council members who reached out to him during a recent illness.

Report of Staff: M. Ross-Russell pointed the group to the HRSA Policy Clarification Document 16-02. She suggested that participants read through the entire document. She noted that the document would be relevant to the planning process moving forward. She stated that the Comprehensive Planning Committee and Finance Committee would be looking at the changes taking place in the Philadelphia EMA due to Medicaid expansion and the ACA.

N. Johns noted that her report on the OHP's recent high-risk heterosexual focus groups was completed and would be available soon.

Public Comment: None.

Action Item:

- **Reallocation Request** – *Finance Committee*

DRAFT

N. Shein stated that the Finance Committee had heard the grantee's reallocation request at their last meeting. She said they had voted to recommend that the Planning Council approve the request. D. Gana stated that the grantee had reworded the request following the Finance Committee meeting.

M. Ross-Russell stated that the grantee requested to move money from Case Management to the Systemwide category of Information and Referral Services, in order to be in compliance with 16-02.

M. Ross-Russell explained that Information and Referral services were provided systemwide. She said that AACO operated a health information helpline in order to help answer questions and get newly-diagnosed individuals linked to care.

R. Colon stated that the request was a reclassification of existing services, and the grantee was making the request due to the wording of 16-02.

M. Ross-Russell stated that the Planning Council annually allocated funding to each of 3 regions in the EMA in order to provide services. She said that, in order to move money from Case Management to a Systemwide (EMA-wide) category, some funding would be taken from Case Management in each of the 3 regions. She pointed the group to the spreadsheets, which demonstrated how much money was moved in each region (*see-attached sheets*).

R. Colon stated that the request would not impact Medical Case Management staffing or service delivery.

M. Ross-Russell explained that the Planning Council was responsible for allocating service dollars based on need. She said that HRSA required all reallocations that impacted a given service category by 5% or more to be approved by the Planning Council. She stated that the EMA had increased this requirement to 10% to provide greater flexibility in light of the ACA and Medicaid expansion. She stated that the request would impact the service category of Information and Referral Services by over 10%.

DRAFT

Motion: The Finance Committee moved that the Planning Council approve the grantee's reallocation request, as demonstrated in the handouts and spreadsheets.

Discussion on the Motion

L. Diaz asked what the money was being reallocated to. M. Ross-Russell explained that Systemwide categories included Administration costs. She added that Information and Referral was a service category, but it was included under Systemwide since it applied to all 3 regions. She stated that Information and Referral Services were provided by AACO's healthcare information helpline.

The grantee distributed a spreadsheet showing allocations EMA-wide (*see-attached sheet*).

Motion passed: 21 in favor, 0 opposed, 2 abstained

Finance Committee – *A. Edelstein, Co-Chair*

A. Edelstein stated that the Finance Committee had reviewed changes in service category descriptions as a result to 16-02. He stated that some changes would be made to the LPAP program locally. He added that the group had reviewed a spreadsheet of funding changes following Medicaid expansion in various EMAs across the country.

Needs Assessment – *G. Keys, Co-Chair*

G. Keys stated that the Needs Assessment Committee would tentatively be meeting on March 21st. She said the group had sent out a transportation survey to local providers. She noted that many responses had

been received already. She said the group would update the RWPC after they reviewed the results of their survey.

Comprehensive Planning Committee – *K. Baron, Co-Chair*
K. Baron stated that the Comprehensive Planning Committee had discussed various service categories of interest, particularly those that would be impacted by 16-02. She said these included Local Pharmaceutical Assistance, Non-Medical Case Management, and Syringe Access. She reported that they would be working on a Health Insurance Premium Cost-Sharing Assistance program. She invited the group to attend the next Comp Planning meeting next Thursday, March 17.

Positive Committee – *K. Carter, Co-Chair*
K. Carter said the Positive Committee would be meeting next Monday, March 14. He stated that the Positive Committee would be addressing some items that were discussed in the Integrated Executive Committee meeting earlier this week. He added that representatives from the LGBT Elder Initiative (LGBTEI) would be presenting at a Positive Committee meeting in the future. He added that an LGBTEI presentation would also be held at Temple University on March 17th.

Nominations Committee – *M. Cappuccilli, Co-Chair*
M. Cappuccilli stated that the Nominations Committee would be meeting later this month on March 24 to review applications for Planning Council membership.

DRAFT

Old Business: None.

New Business: None.

Announcements: None.

Adjournment: **Motion**: L. Diaz made; K. Baron seconded a motion to adjourn the meeting at 2:34p.m. **Motion passed**: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- February 11, 2016 Meeting Minutes
- HRSA Policy Clarification Notice 16-02
- Grantee EMA Reallocation Request (March 10, 2016)
- Reallocation Spreadsheets
- OHP Calendar

January 2015 – December 2015
Outpatient/Ambulatory Medical Care Quality Management Data

April 4, 2016

Dear AACO-funded outpatient/ambulatory medical care providers,

Please find within the most recent edition of the outpatient/ambulatory medical care aggregate data. This document contains the following information:

- January 2015 – December 2015 performance measurement data

As always, I want to thank you for your efforts in collecting data and submitting reports on time.

Next submission: Friday, April 15, 2016

Performance measure reports are due on Friday, April 15, 2016. The measurement period for the performance measure report is "as of" February 29, 2016 (March 1, 2015 – February 29, 2016). Please upload the report (saved as a PDF) to the secure FTP site (https://secure-ftp.phila.gov).

Upcoming Due Dates	Reporting Period	Report Due
April 15, 2016	March 1, 2015 – February 29, 2016	Performance Measure Report

January 2015 – December 2015 Performance Measure Data

We continue to report the *percent change year-to-date.* During this measurement period, we are comparing the January 2015 – December 2015 measurement period to the January – December 2014 measurement period (see table with data below). The *percent change year-to-date* describes the increase or decrease in performance between January – December 2014 and most recent measurement period (January 2015 – December 2015). We use the *percent change year-to-date* to determine if the performance is increasing, staying the same, or decreasing. Similarly, we also use the *change year-to-date* to see the impact that quality improvement plans and activities are making on performance. When AACO staff review the data, we look for at least a 3% increase (3%) or 3% decrease (-3%) *change year-to-date*. The following table lists the performance measures by 3% or more increase; no change; or 3% or more decrease.

Percent Change Year-To-Date Difference between January – December 2014 and January 2015 – December 2015		
Performance measures with a 3% or more increase (↑)	**Performance measures with no change**	**Performance measures with a 3% or more decrease (↓)**
• A10 MSM Receiving Gonorrhea Screening • A12 Colposcopy After Abnormal PAP • Core01 HIV Viral Load Suppression • Core02 Prescription of Antiretroviral Therapy • HAB11 Lipid Screening	• A1 Two Viral Load Counts • A7 MSM Receiving Syphilis Screening • A9 Gonorrhea Screening • Core03 HIV Medical Visit Frequency • Core04 Gap in HIV Medical Visits • HAB03 PCP Prophylaxis • HAB06 Adherence Assessment • HAB07 Cervical Cancer Screening • HAB08 Hepatitis B Vaccination • HAB09 Hepatitis C Screening • HAB10 HIV Risk Counseling • HAB13 Syphilis Screening • HAB14 TB Screening • HAB15 Chlamydia Screening • HAB17 Hepatitis B Screening • HAB19 Influenza Vaccination • HAB21 Mental Health Screening • HAB23 Substance Use Screening	

January 2015 – December 2015
Outpatient/Ambulatory Medical Care Quality Management Data

Highlights for this measurement period:

- 13 programs in the EMA have achieved the NHAS 2020 goal of VL suppression >80%, and 7 programs have achieved the regional goal of 85%. The EMA aggregate has also exceeded the NHAS goal with 82% VL suppression, which is a 3% increase from last year.
- The highest performance for 17 out of 23 performance measures is 90% or greater. Also, the highest performance on Core04 Gap in Medical Visits is 3% (low performance is the goal for this measure).
- The largest improvement from last year's data was in the A12 Colposcopy After Abnormal PAP measure, which increased by 12%.
- For A10 MSM Receiving Gonorrhea Screening, programs should focus on assessing risk, entering NMI to exclude patients where no risk is identified, and implementing the test as a routine annual screening.

January 2015 – December 2015 Philadelphia EMA Data

	Jan - Dec 2012	Jan – Dec 2013	Jan – Dec 2014	Jan – Dec 2015	% change year-to-date (Jan - Dec 2014 to Jan - Dec 2015)	January 2015 – December 2015	
						Lowest performer	Highest performer
A1 Two viral load counts	73%	73%	71%	73%	2%	50%	88%
A7 MSM Receiving Syphilis Screening	85%	87%	89%	89%	0%	50%	100%
A9 Gonorrhea screening	68%	75%	77%	75%	-2%	52%	95%
A10 MSM Receiving Gonorrhea Screening	N/A	N/A	25%	31%	6%	0%	100%
A12 Colposcopy After Abnormal PAP	43%	41%	39%	51%	12%	0%	100%
Core01 HIV Viral Load Suppression	N/A	N/A	79%	82%	3%	60%	88%
Core02 Prescription of ART	N/A	N/A	90%	93%	3%	64%	100%
Core03 HIV Medical Visit Frequency	N/A	N/A	65%	64%	-1%	24%	75%
Core04 Gap in HIV Medical Visits	N/A	N/A	16%	16%	0%	46%	3%
HAB03 PCP prophylaxis	83%	83%	83%	85%	2%	11%	100%
HAB06 Adherence assessment	79%	79%	77%	78%	1%	49%	96%
HAB07 Cervical cancer screening	51%	52%	49%	47%	-2%	11%	76%
HAB08 Hepatitis B vaccination	53%	53%	56%	55%	-1%	19%	92%
HAB09 Hepatitis C screening	90%	92%	92%	92%	0%	56%	100%
HAB10 HIV risk counseling	94%	94%	95%	95%	0%	73%	100%
HAB11 Lipid screening	72%	75%	73%	76%	3%	52%	96%
HAB13 Syphilis screening	78%	79%	81%	80%	-1%	54%	96%
HAB14 TB Screening	74%	78%	77%	76%	-1%	57%	100%
HAB15 Chlamydia screening	68%	76%	77%	76%	-1%	58%	95%
HAB17 Hepatitis B screening	77%	82%	83%	84%	1%	33%	95%
HAB19 Influenza vaccination	51%	59%	53%	52%	-1%	0%	74%
HAB21 Mental Health screening	85%	92%	94%	92%	-2%	50%	100%
HAB23 Substance Abuse screening	84%	91%	92%	94%	2%	58%	100%

As always, please feel free to contact me if you have any questions or concerns.

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