HIV Integrated Planning Council of the Philadelphia EMA
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, January 18, 2018
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Mark Coleman, Tiffany Dominique, Pamela Gorman, La'Seana Jones, Gerry Keys, Dorothy McBride-Wesley, Nicole Miller, Jeanette Murdock, Joseph Roderick, Gail Thomas, Adam Thompson

Excused: Katelyn Baron**,** Dave Gana, Peter Houle, Ann Ricksecker

Absent: Keith Carter

Guests: Sebastian Branca (AACO), Jessica Browne (AACO), Zora Wesley

Staff: Nicole Johns, Stephen Budhu

Call to Order/Introductions: A. Thompson called the meeting to order at 2:04p.m. Those present then introduced themselves.

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

Approval of Minutes (November 16, 2017*)*: A. Thompson presented the November 16, 2017 minutes for approval. **Motion**: G. Keys moved, J. Roderick seconded to approve the minutes. **Motion passed**: All in favor.

Report of Chair: A. Thompson stated he has not received any co-chair nominations. He stated he would like to nominate T. Dominique. He asked T. Dominique if she would accept the nomination. T. Dominique replied she would accept the nomination and the committee proceeded to vote.

Motion: The committee moved to elect T. Dominique as the new co-chair. **Motion Passed**: All in favor.

Report of Staff: N. Johns informed the committee their meeting packet was hefty today. So she would review the packet contents for clarity. The meeting packet included a Linking to Care checklist, results from the November brainstorming, and AACO Ryan White Program Services standards. She noted in the brainstorming review handout, ideas were grouped under green, yellow and red, to identify feasibility.

N. Johns stated the Office of HIV Planning would be hosting an overdose reversal training by Prevention Point on Friday, February 9, 2018 from 12-2 pm. She informed the committee an RSVP was necessary to attend and the Office of HIV Planning would not be providing lunch or reimbursing for transportation. All are welcome to bring their lunch. She stated members could RSVP with her after this meeting, or wait for an email link to be sent out.

Discussion Items:

- **Review and prioritization of retention brainstorming notes.**

A. Thompson reminded the committee from their November meeting they participated in a brainstorming activity about barriers to retention of care. He informed the committee that the OHP has sorted the brainstorming ideas from last meeting into three color categories: green (possible/probable), yellow (maybe someday), and red (not possible/not likely under current conditions).

A. Thompson asked the committee to review the brainstorming notes handout and he shared the categories with the committee.

Green:

- Check on access to mailed day passes via Medicaid for people staying in homeless
- Develop communication tools, and resources for MCM to increase knowledge of Ryan White services in the EMA
- Create more specific patient satisfaction surveys that seek information about interactions with different staff, including front/desk reception and scheduling
- Integrating mental health and behavioral health at Ryan White clinical sites
- “Secret Shopper” focusing on how costs are communicated
- Support groups for PLWH throughout the EMA
- Non-medical case management/including peers
- Monthly transit passes for PLWH living in poverty documented need for such an intervention
- MCM to have access to transit day passes/tokens for clients with problems accessing MA day passes.
- Guidance on reporting issues, formal complaint process
- Invite state-level Medicaid transportation person to a meeting
- Agency level about Ryan White program for all staff

Yellow

- Providers to develop handouts about costs/fees for services to be given at appointments
- Assess outreach services for consistency throughout the EMA- to ensure equitable access to services
- Home visits by non-professionals for social support and barrier reductions (non-medical case managers or navigators)
- Service recovery training
- Enhanced Personal Contact at Ryan White clinics (possibly by peers)/peers as care team members
- Peer receptionists/front desk staff
- On demand transportation options for PLWH who are at risk of falling out of care or missing appointments due to documented transportation barriers
- Checklist for HIV testers

Red

- Family/friends reimbursement for transportation
- Social activities for PLWH not about HIV

A. Thompson explained S. Branca and J. Browne have been given red, yellow, and green cards to signify the feasibility of conversation topics in the meeting. He reminded the committee green refers to probable, yellow is possibly, and red signifies not likely under current conditions.

Red
G. Thomas reviewed the handout and asked why family/friends reimbursement for transportation was listed under the red category. She stated the idea was a useful strategy to help alleviate the issues with medial transportation. S. Branca and J. Browne raised red cards to signify the idea was not likely. A. Thompson replied the Ryan White grant could fund a vendor for transportation but not an individual. He continued if your relative owned a transportation company, the company could bid on the transportation contract. He stated in New Jersey, UBER was being funded by the transportation budget and in theory a relative could be reimbursed for transportation if they were employed under UBER. S. Branca stated staff reimbursement for transportation was funded but it was very unlikely any other funding for individual transportation could happen. He stated the issue with the family/friends reimbursement for transportation mainly is liability. He explained there would have to be some type of proof that drivers had insurance and the car being used to transport the client was not owned by the client. S. Branca added he asked second opinions about this topic and it was universal that it was not possible at this time. A. Thompson asked if it was possible for individuals to be reimbursed with gas cards under medical case management. S. Branca replied he was not sure if the Recipient had a mechanism in place. N. Johns explained there is mention for gas card reimbursement in Ryan White and its handled by subrecipients. A. Thompson stated family/friends reimbursement for transportation was not possible under current Ryan White legislation. He added agencies could have staff members provide transportation since transportation was arguably the number one barrier to retention in care. S. Branca replied it was possible to reimburse staff members for transportation under current legislation. A. Thompson proposed the committee could augment the recommendation from friends and family reimbursement to staff member reimbursement. He noted if the committee changed the recommendation, the topic could be revisited in later meetings.

A. Thompson reviewed the other idea under the red category, social activities for PLWH not about HIV. S. Branca and J. Browne raised their red cards to signify the recommendation was unlikely to happen. A. Thompson asked even though Ryan White grants did not fund non-HIV social activities, could the HIPC promote or announce events that are held at other agencies. S. Branca replied there were other agencies that held social events, and the HIPC could help disseminate information about these events. He noted the HIPC could promote or announce these events they just couldn't fund them. S. Branca added these social events helped with social isolation of PLWH, and these agencies were actually encouraged to have these events periodically. He noted, the Recipient was aware of the effects of social isolation in PLWH, but current Ryan White legislation explicitly stated funds cannot be spent in recreational activities.

A. Thompson explained the committee should look to see how those events are coordinated and begin to promote them.

Yellow
A. Thompson stated there are two recommendations under the yellow category that have been promoted to the green category: Service recovery training, Checklist for HIV testers.

Providers to develop handout about costs/fees for services to be given at appointments.
A. Thompson asked N. Johns why this recommendation was listed as yellow. N. Johns explained the idea was under the yellow category because it was a feasibility issue with providers. She noted the recommendation was closer to the green category than the red category. S. Branca responded the idea is yellow not because of legal barriers but rather a logistic issue. He stated it would be very difficult to make a single flyer that was able to capture all or even the majority of fees for a single provider.

He explained there are numerous insurance coverages that all have different co-pays, different services offered by providers, and other variables to be considered. He suggested the best course of action maybe for providers to have a flyer that explains PLWH will get care regardless of insurance or co-pay status.

S. Branca stated the Recipient conducts anonymous calls (sometimes known as secret shoppers) to providers and assesses the providers' ability to explain fees to their patients. From these calls the Recipient has noticed the explanation of the sliding fee scale is one of the most common issues. He explained one of the biggest barriers to care is when consumers think they have a particular co-pay but then are hit with a sliding fee scale. He noted sliding fee scales are usually "over-simplified" by providers, and cannot be accurately explained over the phone.

S. Branca stated aside from sliding fees, providers often do not screen calls correctly. He stated in many cases providers fail to identify those who are covered under Ryan White, so fees are not accurately explained. When people are hit with fees that are unexpected they may fail to remain in care. A. Thompson asked if providers were required to have sliding fee scales, and S. Branca replied yes. A. Thompson stated besides the few large-scale providers, many providers do not have documents that explain their sliding fee scale or a flyer about the scale itself. A. Thompson stated a comprehensive sliding fee scale flyer was not practical but suggested a sliding fee scale for uninsured persons, and persons with Medicaid insurance. A. Thompson asked the committee what information they think the provider should provide before the visit on the phone and during the visit in-person. P. Gorman shared what her agency does to explain sliding fee scales to their patients. P. Gorman stated her agency hands out flyers that explain they collect co-pays and there may be an out-of-pocket deductible for service. She stated no figures were on the flyer but it says see care coordinator if there were further questions. She stated explaining a sliding fee scale to patients is not an easy explanation and in many cases it's not applicable to many consumers especially those on Medicare/Medicaid.

S. Branca stated the most important thing is to make sure people are aware they will receive care regardless of cost. He explained providers should reiterate this instead of trying to explain a sliding fee scale to a consumer. All that needed to be said by providers is if you're on Medicaid/Medicare and have income at or below the Federal Poverty Line (FPL) you will not have to pay a fee, if your income is above the FPL you may have a fee associated with your services that will be proportional to your income. He stated in theory the sliding fee scale does work but it gets misconstrued by providers. He explained the Recipient conducts phone screens to providers and sometimes the provider misinforms them about out of pocket cost. As a result of Recipient phone screens many providers have adopted a script for the front desk. Providers now test their front desks on occasion and encourage them not to deviate from the script. T. Dominique stated she agreed with the script idea for providers. She noted the issues with fees were most common when providers misinformed consumers over the phone; with a clear concise script these misconceptions will be avoided. T. Dominique suggested providers can also screen patients while they are filling out personal information. She explained since you're asked to fill out paperwork during medical visits anyway, the paperwork could include questions about insurance coverage and status. A. Thompson asked S. Branca if he could obtain a sample script for the committee. S. Branca replied it was possible. A. Thompson stated the script could be evaluated and possibly even included in the "Checklist for HIV testers" recommendation. He noted many people do not even go to their providers when they told over the phone they will have to pay.

P. Gorman stated one of the biggest barriers to care is receiving a bill when the consumer is not supposed to.

A. Thompson asked if the Recipient collects data about those who receive bills that shouldn't? S. Branca relied the Recipient does not collect information of that nature since they do not have a direct relationship with the client. A. Thompson suggested the formal recommendation the committee should bring forward is: identify the telephone script for providers, signage that explains fees in waiting rooms, and to tie this into the HIV checklist. P. Gorman stated her organization uses laminated signs in their waiting room that explain fees may be applied to services received. She noted she would try and bring in examples in a future meeting. S. Branca added fees were a significant barrier to retention; from anonymous calling by the Recipient providers have improved their explanation of fees. He noted new problems can still arise when front desk personnel are stressed or flustered.

Access outreach services for consistency throughout the EMA- to ensure equitable access to services

N. Johns stated this idea was listed as yellow because the 3 health departments (New Jersey, Philadelphia and Pennsylvania) have different budgets and priorities, but in theory the recommendation was possible. A. Thompson stated the recommendation is to make sure the same services were available across the EMA. He referenced New Jersey services that were not available in Pennsylvania*

S. Branca stated the Recipient tried to make services consistent through past medical case management model that required medical case managers to make home visits. He explained a care outreach service was funded about 5 years ago and it was unsuccessful. He explained the medical case management model was changed because it was a uniform requirement that medical case managers made home visits, he noted this was not feasible because different organizations have different budgets. He noted the new medical case management model called for a lower frequency of home visits, and home visit frequency depends upon needs of the client.

S. Branca stated the Recipient found the most cost-effective strategy for service consistency is using a data to care plan*. P. Gorman asked what is data to care. S. Branca replied data to care is using HIV Surveillance data to identify PLWH who are not retained in care.

T. Dominique stated she was in contact with Dr. Brady about data to care program (Project CoRECT). She stated Dr. Brady would attend upcoming committee meetings in the spring to talk about Project CoRECT and its successes. S. Branca noted the Recipient has been involved with other data to care projects besides CoRECT.

A. Thompson stated New Jersey is trying a new plan where community-based organizations (CBOs) are pairing with HIV clinical providers for outreach. He noted from this approach both the community aspect and clinical aspect of care would be included. He emphasized this was a new plan and there is no data on its efficacy yet. He stated this data to care plan was used in other states and had a high success rate. A. Thompson suggested the recommendation should be tabled until there is information about the effectiveness of the data pilots.

T. Dominique stated Project CoRECT was using DIS to reach people who are out of care. A. Thompson talked about his experiences with DIS, and shared his displeasure.

- This conversation was in reference to how New Jersey funds community health workers to do home visits (non-medical case management). Non-medical case management is not funded under Ryan White Part A but New Jersey made mandates that the required community health workers to make home visits and funded it through 340B rebates
- For more information about data to care visit https://effectiveinterventions.cdc.gov/docs/default-source/data-to-care-d2c/pdf-of-important-considerations.pdf?sfvrsn=0

S. Branca stated DIS was working to improve their reputation in the LGBTQ community. He explained the Recipient has worked with DIS to improve outreach.

Home visits by non-professionals for social support and barrier reductions (non-medical case managers or navigators?).
A. Thompson stated this recommendation was tough because these positions are not funded under the Ryan White Part A grant. He asked the committee what their thoughts were about peer-based home visits. P. Gorman stated her agency has outreach workers that can conduct home visits and in some cases non-medical case managers do that as well. S. Branca stated home-visits do happen but there is no direct funding for it. S. Branca referenced his earlier comments about the new case management model. A. Thompson stated personally he would feel more comfortable if a peer came to his home for a visit over a medical professional.

S. Branca stated those who were not virally-suppressed, newly diagnosed with HIV, and those with other comorbidities were more likely to need more comprehensive services. He explained under the current medical case management model, home visits could be funded. S. Branca stated despite the challenges that are faced in the Philadelphia EMA, the viral-suppression rate of 87.1% is the highest of a big city according to HRSA.

L. Jones suggested the Recipient and HIV clinical providers could use surveillance to identify clients who are lost-to-care, and have fallen off medical case management. She stated non-medical case managers could make home visits and to see why the client has fallen out of care. She added the client may benefit more from peer-based visits. A. Thompson agreed and stated data has shown peers with shared life experiences can deliver master's level outcomes. He suggested the committee should table the recommendation until the Recipient presents the new medical case management model to the HIPC.

Enhanced Personal Contact at Ryan White clinics (possibly by peers)/peers as care team members
A. Thompson stated this was in reference to K. Baron's suggestion from the previous meeting. S. Branca stated this recommendation was evidence-based, and was fully supported by the Recipient. He explained the new case management model increased the amount of required contact for those in high need of care. The model required face-to-face contact every 90 days, and phone contact every 30 days. He noted the model did decrease the amount of necessary in-person contact for those who have had improved health status to twice a year.

N. Johns explained a few years ago the committee discussed linkage and retention navigation programs. From that work the committee identified some evidence-based interventions. She stated the ideas were straight forward and pertaining to contacting people before their appointments to verify transportation, contact if an appointment was missed, and contact to ensure treatment adherence. S. Branca stated there were studies that he was familiar with that supported enhanced personal contact. He explained client contact was time dependent and there was a small window of time you had to contact a client after a missed appointment for the strategy to be successful. A. Thompson asked who was the target audience for the intervention, is it the program directors or the staff answering the phone calls? S. Branca replied for the intervention to be successful program directors must be included. He stated the program directors can adjust their programs to adhere to the intervention which will make the intervention successful.
T. Dominique stated her organization uses enhanced personal contact during their research studies. She explained the researchers will contact clients 1 hour after a missed appointment. She

added this type of contact makes people feel important, and shared her experience with enhanced personal contact. She noted things as simple as remembering your client's birthday goes a long way. She noted she sent up her email account to automatically send happy birthday emails to her clients.

Peer receptionists/front desk staff

A. Thompson stated he loves the idea but its yellow because there is no way to make organizations hire individuals. S. Branca stated there was a legal issue with the hiring process. He explained a limited range of language can be asked on a job application or interview. A. Thompson stated in New Jersey employers use the term “shared-lived experience” to hire individuals. A. Thompson stated with the use of this language there is little to no legal ramifications. He asked what the committee thought of this language or hiring peer workers.

P. Gorman referenced the hiring process and stated many institutions screen out applicants by using a personality screening test so peer applicants may not even make it to the interview process. She stated in her opinion a person’s HIV status is negligible and organizations should look for the people who are from the area. She explained people from the same area often share the same experiences as their peers regardless of serostatus, and are often aware of stigma.

J. Murdock stated she doesn’t think receptionists need to be PLWH, but rather just people who were aware of HIV and the stigma that surrounds HIV. D. McBride-Wesley stated receptionists need to be trained better and more understanding of PLWH, especially elderly PLWH.

S. Branca responded he agrees front desk staff needs to be better informed. He stated it is important to remember front desk staff are often over-stressed and can sometimes provide a sub-par greeting to PLWH based on their workload. That sub-par greeting may be offensive or even stigmatizing even though that may not have been its intended nature. He also explained the front desk staff in many hospitals may not be specific to the infectious disease clinic, and often lack training to effectively communicate with PLWH.

S. Branca stated from anonymous calls to front desks of providers, the Recipient has been become aware of communication issues. He stated some organizations have even suggested using peer-based workers. He reiterated the legal issues surrounding peer-based hires, and suggested organization could do recruitment in areas with high PLWH populations. He noted the only issue was where to recruit from.

L. Jones suggested organizations could use specific language on their applications to target PLWH. She explained applications could ask for a high school diploma or GED equivalent, and require applicants to be 18 or older for entry level positions.

A. Thompson suggested the committee could encourage the development of a “pipeline” for PLWH seeking employment, he stated a similar process was used in the youth Black MSM leadership organization. He stated from this pipeline no recruitment would have to be done and employers would have a resource of PLWH looking for employment. Two needs would essentially be filled employment for PLWH, and employers filling jobs with qualified individuals. He suggested the committee could make a recommendation to create this pipeline for PLWH.

A. Thompson proposed the committee could use the “ambassador/ buddy system” that’s used by community organizations, where volunteer PLWH work at a CBO in roles like reception and can be hired as staff eventually.

N. Johns suggested the committee could use the Positive Committee to host some trainings, but Ryan White funds cannot be used for employment readiness.

Z. Wesley suggested the committee could look to establish local partnerships with colleges to give employment training for PLWH. She explained many entry level positions require educational training.

J. Murdock emphasized the importance of volunteer programs for employment training. She shared her experiences with volunteering and explained how volunteering improved her networking ability.

On demand transportation options for PLWH who are risk of falling out of care or missing appointments due to documented transportation barriers.

S. Branca informed the committee the issue with alternative transportation is mainly insurance. He explained the Recipient had some concerns about legality regarding insurance and coverages of UBER drivers. A. Thompson stated another issue with UBER is surge pricing. S. Branca noted there were some legislative barriers that restricted funding transportation with varying pricing.

P. Gorman suggested the committee could recommend monthly SEPTA passes instead of day passes. S. Branca replied the Recipient does not feel that monthly passes were justified for Ryan White clients since a monthly pass is $96 and it translates to 28 rides. He explained most PLWH likely do not visit medical providers 48 times in a month. T. Dominique stated the Recipient could use the SEPTA key which can be loaded when necessary. She explained the Recipient can issue blank SEPTA key cards and they can be loaded when the client has an appointment. She stated the Recipient would just have to keep track of the SEPTA Key ID number and who the card was issued to. S. Branca stated he would bring this recommendation back to the Recipient.

M. Coleman shared his experiences with the SEPTA changes and the transition to the SEPTA Key. He explained only a few stations still accept tokens so the changeover to SEPTA Key was inevitable.

P. Gorman asked if Philadelphia uses taxis. N. Johns replied yes, and Ryan White still uses taxi vouchers. P. Gorman suggested the committee could look to contract taxi cab services instead of ride services since they do not use surge pricing.

Old Business: None

New Business: None

Announcements: None

Adjournment: Meeting adjourned by consensus at 4:00 pm

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- November 16, 2017 minutes
- Meeting Agenda
- Linkage to Care guideline
- Ryan White program services guideline
- Emergency Financial Assistance guidelines
- Pyscho-Social support information handout
- Brainstorming handout
- OHP Calendar