

HIV Integrated Planning Council

Meeting Minutes

Thursday, June 8, 2017

2:00-4:00p.m.

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Juan Baez, Katelyn Baron, Kevin Burns, Michael Cappuccilli, Keith Carter, Mark Coleman, Lupe Diaz, Tiffany Dominique, Alan Edelstein, Gus Grannan, Sharee Heaven, Gerry Keys, Loretta Matus, Nicole Miller, Jeanette Murdock, Christine Quimby, Joseph Roderick, Samuel Romero, Clint Steib, James Tarver, Adam Thompson, Leroy Way

Excused: Tre Alexander, Jen Chapman, Tessa Fox, David Gana, Peter Houle, Gail Thomas

Absent: Henry Bennett, Jonnie Bradley, Bikim Brown, Karen Coleman, Cheryl Dennis, Pamela Gorman, Sayuri Lio, Abraham Mejia, Carlos Sanchez, Nurit Shein, Lorrita Wellington

Guests: James Breinig, Coleman Terrell (AACO), Derrick Wilson (AACO), Chris Chu (AACO), Caitlin Conyngham (AACO), Ameenah McCann-Woods (AACO), Casey Johnson, Evelyn Torres (AACO), Nina Gurak, John Plotz, Brian Shim, Alex Grayson, Roberta Irvin, Maggie Schepiro, Dottie McBride-Wesley, La'Seana James, Lynette Trawick

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

Call to Order: K. Baron called the meeting to order at 2:08p.m.

Welcome/Introductions/Icebreaker Activity K. Baron welcomed HIV Integrated Planning Council (HIPC) members and guests. Those present then introduced themselves.

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

Recap of Previous Meeting: K. Baron reported that at their last meeting the Planning Council received a treatment update from Dr. David Condoluci. They also voted to approve the priority setting process developed by the Comprehensive Planning Committee and received updates to the bylaws for review.

Approval of Planning Council Minutes (May 11, 2017): K. Baron presented the minutes for approval. **Motion:** G. Keys moved, L. Way seconded to approve the May 11, 2017 minutes. **Motion passed:** All in favor.

Report of Co-Chair: K. Baron stated that the co-chairs were going to talk about each committee of the HIPC in the coming months. She said that anyone with further questions following the presentations could talk to the co-chairs of the individual committees.

K. Baron said that she'd discuss the Comprehensive Planning Committee (CPC) at today's meeting. She said the committee would be meeting next Thursday, June 15 from 2-4pm. She explained that the CPC reviewed, investigated, deliberated, and monitored the Integrated HIV Prevention and Care Plan. She stated that the Plan was completed last summer and was written by OHP staff in collaboration with AACO, the HPG, and the RWPC, though the CPC participated in the process as well. She noted that priority setting had begun last month. She explained that the CPC had reviewed service category definitions and begun to discuss each service category. She noted that the CPC had recently done work around health insurance premium and cost-sharing assistance and developed a retention navigation model.

She said that anyone with questions could speak with Adam Thompson, chair of CPC. She noted that CPC meetings were open to the public. She encouraged all members and guests to attend.

Report of Staff: None.

Public Comment: None.

Special Presentation:

- **Counseling and Testing Presentation** – *Derrick Wilson and Caitlin Conyngham, AACO*

D. Wilson stated that he and C. Conyngham would be talking about the recent AACO counseling and testing survey, its findings, and the next steps they had in mind. He said that the CDC released updates on their expectations for HIV testing in 2012. He noted that this brought about a shift in HIV testing. He said they'd switched from the idea of behavior change to a test and link to care modality. He stated that the shift required redesigning trainings for new testers. He added that existing testing staff had also been retrained. He stated that, in the last year, AACO representatives had visited agencies to train them on the new model for testing. He said that the survey he'd be presenting on today was developed to identify gaps and needs in the training process.

D. Wilson noted that there had been changes in HIV prevention. He stated that PrEP was approved for use in 2012. He added that, as emphasized by the National Institutes of Health (NIH), viral suppression lowered the rate of HIV transmission to 0, which was known as treatment as prevention.

D. Wilson noted that HIV testing was the gateway to treatment and prevention. He said that someone who tested positive was directed to care services along the continuum, and those who tested negative were directed to services along the prevention continuum. He said that there was overlap between the two continuums.

D. Wilson stated that HIV testers were key frontline staff for ending the HIV epidemic, so investing in their training was very important. He said the survey was distributed to testers using SurveyMonkey.

C. Conyngham said she'd be talking about the survey and its findings. She said the survey was distributed to 100 frontline testers and their direct supervisors by email. She stated that the testers worked for funded programs in Philadelphia. She noted that 4 reminder emails were sent, and the survey was conducted over 3 weeks. She stated that it was administered to HIV testers across 17 agencies, with a 70% response rate.

C. Conyngham said the survey had 27 questions, with 11 multiple choice and 14 Likert scale responses (ranked from strongly disagree to strongly agree). She added that 2 questions regarded future capacity building opportunities. She reviewed survey findings. She stated that 51% of respondents were working in HIV services for 6 or more years. She noted that 55% of these individuals were working at their agency for fewer than 3 years. She added that 58% began their careers as HIV testers prior to FDA approval of PrEP. She noted that the findings suggested high staff turnover among HIV testers. She stated that 87% of respondents viewed HIV testing as a critical part of ending the HIV epidemic.

C. Conyngham noted that the survey contained questions about PrEP and nPEP. She said 93% of respondents could accurately identify PrEP and nPEP. She stated that 67% answered "neutral" to "strongly agree" that they believed PrEP increased HIV risk behaviors. She stated that 77% identified lack of insurance as a barrier to PrEP. She noted that 61% answered neutral to strongly agree that they needed more training to offer PrEP to their clients. She said that PrEP was the highest ranked topic for desired future training.

C. Conyngham moved on to HIV treatment questions. She said that 30% of testers thought HIV medications were toxic. She added that 16% believed that HIV-positive people needed insurance to access HIV services. She reported that 59% believed that treatment as prevention did not work. She noted that the findings suggested barriers to linkage to care for newly-diagnosed people.

C. Conyngham stated that 98% of respondents believed that outreach to priority populations was key to successful testing programs. She added that race and racial disparities in HIV prevention were ranked as high-priority for capacity building among testers. She said testers wished to build capacity in STIs and prevention, opioids, naloxone, syringe access, and transgender cultural competency.

D. Wilson said that AACO would be providing a series of capacity building trainings to the frontline HIV prevention workforce called “TALC 2.0.” He said the goal was to invest in the Philadelphia HIV testing workforce through training. He noted that the trainings were designed to address knowledge gaps and attitudes and beliefs about effective HIV prevention and treatment options. He noted that trainings would be offered to all agencies funded for targeted HIV testing. He said that the trainings were offered at flexible times to accommodate participants. He added that they were mandatory for testers and supervisors.

D. Wilson added that four trainings had been scheduled so far, regarding PrEP, HIV transmission, status-neutral linkage to care, and cultural competence to expand outreach to priority populations. He stated that attendees at trainings so far had been very engaged. He said that, as assessment and feedback continued, more trainings would be offered.

D. Wilson said that AACO was evaluating the trainings with knowledge and training satisfaction evaluations. He stated that the testing survey would be repeated next spring to assess its effectiveness. He said there would be ongoing program monitoring of HIV testing and additional trainings as necessary, including for managers and other staff.

M. Cappuccilli asked if the 17 agencies surveyed were funded in Philadelphia. C. Conyngham replied that they were. M. Cappuccilli asked if the trainings were standardized for new hires. D. Wilson responded that new testers had to go through a testing and linkage to care (TALC) training program. He stated that training had changed so radically over the past several years that existing staff needed to be retrained. M. Cappuccilli asked if staff had been periodically retrained before this program began. D. Wilson said that testers had been required to do 10 hours of ongoing training per year. He stated that he’d personally received his first testing training in 1995 and hadn’t received a standardized training since. Therefore, people in situations like his needed updated trainings. C. Conyngham said there was an expectation that ongoing training happened at an agency level. M. Cappuccilli stated that knowledge gaps cited in the survey were significant. D. Wilson said that the knowledge and trust gap had shown a need for updated trainings. He noted that some respondents did not trust PrEP.

A. McCann-Woods noted that testers had previously been trained in the Counseling, Testing, and Referral (CTR) model. She said that the model attempted to change behaviors to reduce risk. She noted that this was a different form of thinking than treatment as prevention. C. Conyngham stated that AACO hoped to encourage agencies to update their own trainings.

A. Thompson asked if the data would be shared outside Philadelphia. C. Conyngham said that one purpose of presenting the data to the Planning Council was to open a conversation with other areas of the EMA. A. Thompson recommended sharing the information outside Philadelphia in other contexts as well. A. Edelstein asked if there were formalized methods of communication with other areas of the EMA to share knowledge about testing. C. Terrell said he had monthly calls with other areas of the EMA.

T. Dominique asked if there would be a formalized relationship with STD control to address knowledge gaps around testing. C. Conyngham said that there were ongoing trainings with disease intervention specialists on PrEP and other topics. She noted the testing trainings were scheduled through 2018. She added that STIs were identified as a high priority training item. She said it was important to prioritize topics in order to get out the most important information without interrupting service delivery.

A participant asked if testers who were not with a funded agency were required to attend the trainings. D. Wilson said the trainings were not mandatory for non-funded agencies. He stated that there was limited space at the trainings. He noted that trainings with space were opened to testers who weren't working at funded agencies as well as the community. He stated that trainers from unfunded agencies and non-testers had been welcomed at a previous training. A participant asked how people could become testers if they weren't with a funded agency. D. Wilson suggested emailing health.aacotraining@phila.gov. He said testers underwent a regional training along with a testing and linkage to care training. He stated that testers had to pass exams. He noted that AACO-funded staff was prioritized to get into the trainings, but waitlists were not long for others who desired to participate.

M. Cappuccilli asked if AACO representatives were surprised by the results of the survey. D. Wilson stated that he was surprised that some testers believed ART was toxic and did not believe in treatment as prevention. He said he was not surprised that some testers felt PrEP increased risk behaviors. C. Conyngham said she had similar thoughts about the survey. She noted that, in the open response questions, many people said they wanted extra capacity building. M. Cappuccilli asked when the survey would be followed up. D. Wilson said that the survey would be repeated annually to assess future training needs and evaluate the effectiveness of ongoing trainings.

- **Case Management Model** – *Evelyn Torres, AACO*

E. Torres said she was the program administrator at AACO. She stated that she'd be sharing information about Ryan White case management services for people living with HIV/AIDS (PLWHA). She said that AACO was looking to set up a binary system for medical case management (MCM) in the Philadelphia EMA. She said she'd placed a fact sheet about the proposed model on the side table.

E. Torres said that staff members of AACO from various departments had begun meeting to address their MCM model. She noted that, currently, one model of MCM was supported by AACO. She said that the proposed binary system included short-term and long-term MCM. She noted that short-term MCM addressed clients' immediate needs and long-term MCM was more intense and ongoing intervention necessary to address retention in care, treatment adherence, and viral load suppression.

E. Torres said that AACO surveyed MCM providers in community-based organizations (CBOs) and medical sites. She stated that they'd examined models across the country in EMAs that had similar populations to Philadelphia. She said that these comparisons along with internal health department analyses supported the new MCM model. She noted that clients were often getting case management sporadically rather than continuously. She noted that case managers had larger caseloads at medical sites, which needed to be managed differently than CBOs.

E. Torres said that more flexibility was needed to reach groups like newly diagnosed PLWHA, people in care who were not yet virally suppressed, people in HIV care who were not adherent to treatment, and people in care who were not retained in care. She said that many new HIV infections were due to people who were unaware of their status or PLWHA who were out of care.

E. Torres said that many MCM requirements were changing. She stated that these included enrollment criteria, documentation, caseloads, monitoring standards, and performance measures. She added that implementation of the new model needed to be within the framework of the HRSA definition of MCM,

including treatment adherence services, service care plans, and improved health outcomes. She noted that medical and non-medical case management was fundable under Ryan White. She stated that Policy Clarification Notice (PCN) 16-02 explained that MCM had to focus on improving health outcomes across the continuum.

E. Torres stated that all MCM service providers in the Philadelphia EMA in all settings should be subject to the new requirements for implementation by March 1, 2018. She noted that AACO was currently holding informational sessions on the proposed changes with MCM providers, clients, and the Planning Council. She said several client sessions had already been held, and the model was being tweaked based on feedback. She stated that some consumers were anxious about the changes due to fear of unwanted discharge from case management. She said that many consumers were working, virally suppressed, and doing well, but were still getting medical case management. She stated that some of these individuals would be candidates for graduated disengagement from the MCM process. She noted that some stable clients wanted to continue seeing a case manager just in case, but there were currently waiting lists for case management.

A. Edelstein stated that the ability of clients to live independently of case management was not binary. E. Torres agreed. T. Dominique asked if there was a possibility of transitioning clients from MCM to non-medical case management as a way of slowly exiting case management. E. Torres said that AACO did not fund non-medical case management. M. Cappuccilli asked if the new model would be more expensive than the previous MCM model. E. Torres said that AACO funded programs rather than a fee-for-service model. She stated that providers were awarded a certain amount of money through the request for proposal (RFP) process.

G. Grannan said that the new MCM model presumed that patients did not always follow through the continuum in a straightforward and predictable way. E. Torres agreed that progress through the continuum was not always linear, which the model attempted to take into account. C. Terrell stated that data suggested that a majority of PLWHA accessed case management sporadically. Therefore, in order to provide the service efficiently, the new model attempted to provide case management to those who most needed it as opposed to those using it just in case.

A. Thompson asked about the distinction between short-term and long-term case management. E. Torres said that, for newly diagnosed PLWHA, short-term case management saw to their immediate needs. She stated that the model would follow up on clients who had been through short-term case management to see if they maintained their viral suppression and engagement in care. A. Thompson stated that people who were in stable treatment generally did not usually stop adhering to treatment without outside factors intervening. He asked if non-medical case management could be used to account for sporadic needs. C. Terrell said that there used to be an acuity system. He stated that everyone who entered case management had acute need. He said that it was important to ensure that people were not dropped from case management prematurely and that it was easy to reenter case management if necessary. A. Thompson noted that people who sporadically accessed case management would stop engaging if they had to undergo extensive evaluation whenever they wanted to re-engage with MCM.

E. Torres stated that she knew of a client who worked with a case manager in order to get job. However, she said the client was in poor health. She noted that MCMs wanted to respect client independence, but clients could not maintain their independence if they did not see to their medical needs. K. Burns said he felt moving clients away from MCM in order to accommodate the needs of those who were not in MCM was a good idea. He stated that people who were sporadically accessing case management often did so for economic reasons that also put them at risk at dropping out of care. He suggested there be an easy way to reenter case management for those who needed to, for as long as they needed it. E. Torres stated that the

AACO Client Services Unit (CSU) would need to examine the role it played in facilitating case management intake through the new binary model.

A. Thompson noted that retention in care was dropping across the country, though viral suppression was increasing. Therefore, he suggested using another measure to for engagement in care.

C. Johnson stated that she engaged with health plans, which were affiliated with case management services. She asked if AACO would be engaging with any of the health plans, and how they would be able to play a role particularly long-term. E. Torres noted that MCM was billable in PA, and they tracked billing to Medicaid. A. Edelstein noted that providers had to have contracts, and were able to decide who they contracted with.

Report of Committees

Executive Committee

K. Baron stated that the Executive Committee had reviewed the Planning Council bylaws, which would be presented to the Planning Council for a vote at their July meeting.

Finance Committee – A. Edelstein and D. Gana, Co-Chairs

No report.

Needs Assessment – G. Keys, Chair

K. Baron stated that the Needs Assessment Committee had met with the Comprehensive Planning Committee.

Positive Committee – K. Carter, Co-Chair

A. Boone said that the Positive Committee had heard a presentation from Siloam and reviewed allocations and priority setting. He noted that they'd be meeting on Monday and talking about the opioid epidemic.

Nominations Committee – M. Cappuccilli and K. Burns, Co-Chairs

M. Cappuccilli said that Nominations had met before the meeting and heard a social media report from A. Boone and J. Hayes. He said that the committee had debriefed on the prevention summit. He said they'd try to move the OHP table to a more central location next year. He added that Nominations was working on the Planning Council application to incorporate prevention language. He stated that they'd distribute questions to Planning Council members to use for social media posts in the July and August meetings.

Comprehensive Planning Committee – A. Thompson, Chair

A. Thompson said the CPC had completed the first half of the priority setting process. He said the second half would be completed at their next meeting on June 15th from 2-4pm. He stated that they would bring the priority setting list to July's HIPC meeting for a vote.

Prevention Committee – L. Matus and C. Steib, Co-Chairs

C. Steib stated that he and L. Matus were the new co-chairs of the Prevention Committee. He said next month would be their first official meeting as co-chairs. He stated that the committee met on the fourth Wednesday of every month at 2:30pm, though this month they'd meet on the 21st due to a conflict with the Prison Summit. He encouraged all to attend.

Old Business: None.

New Business: None.

Announcements: None.

Adjournment: Motion: M. Cappuccilli moved, L. Way seconded to adjourn the meeting at 3:18p.m.
Motion passed: All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- May 11, 2017 Meeting Minutes
- Ryan White Medical Case Management Program (Handout)
- OHP Calendar