Philadelphia HIV Integrated Planning Council (HIPC)
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, June 15, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: Katelyn Baron, David Gana, Nicole Miller, Gerry Keys, Jeanette Murdock, Gus Grannan, Joe Roderick, Leroy Way, Mark Coleman, Clint Steib, Mike Cappuccilli

Excused: Adam Thompson, Peter Houle

Absent: Keith Carter, Karen Coleman, Lupe Diaz, Ann Ricksecker, Lorrita Wellington

Guests: Jessica Browne (AACO)

Staff: Nicole Johns, Briana Morgan, Jennifer Hayes

Call to Order/Introductions: K. Baron called the meeting to order at 2:03p.m. Those present then introduced themselves.

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

Approval of Minutes *(May 18, 2017)*: K. Baron presented the minutes for approval. **Motion**: D. Gana moved, G. Keys seconded to approve the May 18, 2017 minutes. **Motion passed**: All in favor.

Report of Staff: N. Johns reported that M. Ross-Russell was attending a meeting in Washington, D.C. regarding the allocations and planning process.

Report of Chair: None.

Discussion Items:

- **Priority Setting**

K. Baron explained that the priority setting factors had been changed for this year with the addition of the community conscience factor. She asked the group to reference the handouts in their packets. She stated that the first page included a list of the factors. She said the first four factors were prepopulated in the spreadsheet current displayed on the projector. She noted that these factors included unmet need, measured through data from the Medical Monitoring Project (MMP) AACO Client Services Unit (CSU) intake, and the OHP consumer survey. She added that other factors included the consumer survey, the care continuum previously developed by the Comprehensive Planning Committee, and Essential Health Benefits.

She read the definition of the community conscience factor. She explained that the group would vote 1, 5, or 8 on each service category based on whether or not they felt the need for the service was adequately captured by the other factors. She stated 1 indicated neutrality on

whether or not the service was represented by other factors, 5 indicated some concern, and 8 indicated great concern. She stated that N. Johns would list the scores for community conscience for each service category on the board at the front of the room as the group voted on them.

Home & Community-based Health Services
K. Baron reviewed the scores for the category on the first 4 factors (*see attached sheets*). She explained that the scores were based on the data included in the packets. She noted that the essential health benefit factor may change based on future policy shifts, but right now the group would be using it. K. Baron asked for clarification on the definition of the category. N. Johns read off the category as laid out in Policy Clarification Notice (PCN) 16-02[1].

D. Gana asked if any comments were made about the service on the consumer survey. N. Johns replied that there weren't. She noted that the service was at the bottom of the list on the consumer survey question regarding needs for services. She added that services that fell under this category may also be provided by insurance. She noted that the service was not called by its name on the consumer survey. Rather, it was described based on its function.

Vote: 11 members voted 1 on the community conscience factor for the home & community-based health services category.

M. Cappuccilli asked for an explanation of the scores of 5 and 8 on the community conscience factor. K. Baron explained that 5 indicated some concern that the need for the service was not adequately captured by data on other factors, whereas 8 indicated great concern.

Home Health Care
N. Johns read the definition of the service from PCN 16-02[2]. K. Baron reviewed the data for the service category on the prior 4 factors.

Vote: 11 members voted 1 on the community conscience factor for the home health care service category.

Hospice Services

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[1]Home and Community-Based Health Services are provided to a client living with HIV in an integrated setting appropriate to a client's needs, based on a written plan of care established by a medical care team under the direction of a licensed clinical provider. Services include:
• Appropriate mental health, developmental, and rehabilitation services
• Day treatment or other partial hospitalization services
• Durable medical equipment
• Home health aide services and personal care services in the home.

[2]Home Health Care is the provision of services in the home that are appropriate to a client's needs and are performed by licensed professionals. Services must relate to the client's HIV disease and may include:
• Administration of prescribed therapeutics (e.g. intravenous and aerosolized treatment, and parenteral feeding)
• Preventive and specialty care
• Wound care
• Routine diagnostics testing administered in the home

K. Baron reviewed the data for the category in the previous 4 factors.

G. Keys stated that hospice services were widely available for those who needed them.

Vote: 1 member voted 5, and 10 members voted 1 on the community conscience factor for the hospice services category.

Housing Assistance
N. Johns read the definition of the housing assistance category from PCN 16-02[3]. She noted that housing assistance could not be delivered in the form of direct cash payments to clients. She stated that the service was for emergency, short-term assistance and housing counseling.

K. Baron noted that housing had high scores under the first 4 factors. She said that 51% of people cited housing as a need according to AACO CSU data.

D. Gana stated that some people who reported unmet need for housing were referring to forms of housing other than Ryan White housing services. G. Grannan said that short-term need for housing did exist. M. Cappuccilli asked how housing assistance was funded. N. Johns stated that housing for PLWHA was funded by HOPWA, Section 8, and Ryan White (on a temporary basis). She noted that the service category also included housing assistance and homelessness prevention programs.

K. Baron said that housing was included in "retained in care" and "viral suppression" along the care continuum. She stated that it was only included in these 2 categories because, in order to access Ryan White housing, consumers needed to already be in care.

N. Johns suggested the group review the last handout in their packets, containing excerpts from question 57 on the consumer survey.

N. Johns noted that, in the Philadelphia EMA, housing was administered as emergency rental assistance, transitional group residential housing, and housing assistance (legal representation for evictions, etc). D. Gana said assistance was also available to help people get housing. N. Johns added that housing support was also available through Ryan White.

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[3] Housing services provide transitional, short-term, or emergency housing assistance to enable a client or family to gain or maintain outpatient/ambulatory health services and treatment. Housing services include housing referral services and transitional, short-term, or emergency housing assistance.

Transitional, short-term, or emergency housing provides temporary assistance necessary to prevent homelessness and to gain or maintain access to medical care. Housing services must also include the development of an individualized housing plan, updated annually, to guide the client's linkage to permanent housing. Housing services also can include housing referral services: assessment, search, placement, and advocacy services; as well as fees associated with these services.

Eligible housing can include either housing that:
• Provides some type of core medical or support services (such as residential substance use disorder services or mental health services, residential foster care, or assisted living residential services); or
• Does not provide direct core medical or support services, but is essential for a client or family to gain or maintain access to and compliance with HIV-related outpatient/ambulatory health services and treatment. The necessity of housing services for the purposes of medical care must be documented.

Vote: 1 member voted 8, 6 members voted 5, and 4 members voted 1 on the community conscience factor for the housing assistance service category.

Information and Referral
K. Baron reviewed the scores for the service category in each of the first four factors.

Vote: 1 member voted 5, and 10 members voted 1 on the community conscience factor for the information and referral service category.

Legal Services
N. Johns noted that legal services was now included in the "other professional services" category. However, she stated that legal services were the only services funded under that category in the Philadelphia EMA.

K. Baron noted that legal services were expensive, and there seemed to be a high need for them.

D. Gana stated that some people did not know what legal services were available. He said they may be unaware of some of the organizations that provided legal services. He speculated that there were communication issues about the services in the community.

G. Keys said that some people did not understand what they could use legal services for. She stated that some may believe that legal services were only available for discrimination cases. K. Baron explained that it may be difficult for people outside the legal field to understand legal services. She noted that legal services encompassed many services.

C. Steib asked if providers knew which legal services were available. K. Baron stated that the lack of knowledge was likely shared between providers and consumers. M. Cappuccilli said that there had not been a presentation from an organization that delivered legal services. N. Johns stated that a representative from the AIDS Law Project had presented about public insurance benefits, which constituted an important legal service provided by that organization.

M. Coleman suggested that AIDS Service Organizations (ASOs) providing legal services remove the word "AIDS" from their name due to issues of stigma. K. Baron suggested the Planning Council request a presentation from AIDS Law Project about legal services.

Vote: 7 members voted 5, and 5 members voted 1 on the community conscience factor for the legal services category.

Local Pharmaceutical Assistance
N. Johns read off the definition of local pharmaceutical assistance from PCN 16-02[4]. She reiterated that the service could only be accessed if there was a restricted AIDS Drug

[4] AIDS Pharmaceutical Assistance services fall into two categories, based on RWHAP Part funding.

Assistance Program (ADAP) formulary or a waitlist for ADAP. N. Johns noted that, at their previous priority setting meeting, the group had discussed access to emergency medications through Direct Emergency Financial Assistance (DEFA). She stated that DEFA was used to provide emergency medications in the Philadelphia EMA. She explained that this category was used for people who did not have access to ADAP.

K. Baron reviewed the scores for the service category in the first four factors. She asked if the unmet need scores could reflect need that was fulfilled in a category other than this one.

M. Coleman asked what organizations that had underspending did with their money. N. Johns stated that providers that could not spend Ryan White money gave it back to AACO. Then, AACO redistributed the money to other service categories where there was a need, with approval from the Planning Council for changes over 10%. K. Baron stated that underspending was often due to unfilled positions. She said that the EMA had a process to help ensure funding was spent in an efficient manner.

Vote: 2 members voted 5, and 10 members voted 1 on the community conscience factor for the local pharmaceutical assistance service category.

Medical Case Management
K. Baron reviewed the scores for the first four priority setting factors.

M. Coleman asked if people with substance use disorders could be more difficult for case managers to help. G. Grannan stated that there were no specific case managers for people who injected drugs (PWID). He said that there were questions as to whether or not PWID were appropriately served by medical case management. He said that it was important that they be served in organizations that had sufficient cultural competency around PWID.

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1. Local Pharmaceutical Assistance Program (LPAP) is operated by a RWHAP Part A or B recipient or subrecipient as a supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria.

RWHAP Part A or B recipients using the LPAP service category must establish the following:

- Uniform benefits for all enrolled clients throughout the service area
- A recordkeeping system for distributed medications
- An LPAP advisory board
- A drug formulary approved by the local advisory committee/board
- A drug distribution system
- A client enrollment and eligibility determination process that includes screening for ADAP and LPAP eligibility with rescreening at minimum of every six months
- Coordination with the state's RWHAP Part B ADAP
    - A statement of need should specify restrictions of the state ADAP and the need for the LPAP
- Implementation in accordance with requirements of the 340B Drug Pricing Program and the Prime Vendor Program

2. Community Pharmaceutical Assistance Program is provided by a RWHAP Part C or D recipient for the provision of long-term medication assistance to eligible clients in the absence of any other resources. The medication assistance must be greater than 90 days.

J. Murdock asked if case managers were responsible for providing emergency financial assistance through gift cards. N. Johns stated that she didn't believe that the program J. Murdock was referring to was a Ryan White program. She explained that Ryan White couldn't pay for various needs, like clothing. She stated that Ryan White could pay for food vouchers. She said that access to food vouchers was based on eligibility and availability.

G. Grannan stated that he believed food vouchers were provided by non-medical case managers, some of whom were not funded by Ryan White to provide the service. K. Baron said that people who were having issues with certain service providers could call AACO's health information helpline[5].

Vote: 12 members voted 1 on the community conscience factor for the medical case management service category.

Mental Health Therapy/Counseling
K. Baron reviewed the scores on the previous 4 factors for the service category. She said that she believed the unmet need score was low. She explained that a score of 1 in the essential health benefit factor meant that the service was covered as an essential health benefit.

Vote: 1 member voted 8, 4 members voted 5, and 7 members voted 1 on the community conscience factor for the mental health therapy/counseling service category.

Nutritional Services
K. Baron noted that this category was different from the food bank/home-delivered meals category. N. Johns stated that it referred to nutritional counseling provided by professionals. K. Baron reviewed the scores in the service category in the first 4 factors.

J. Murdock said she believed there was a need for nutritional services. She stated that many providers did not have that service available. She noted that she had diabetes, and she found nutritional counseling helpful. K. Baron stated that chronic medical conditions often responded to changes in diet.

G. Grannan said that some people lived in areas that did not have healthy food available. He asked if nutritional services could help people get to healthy food. N. Johns replied that it could not. J. Murdock said that nutritional counseling could help with disordered eating. She stated that some people did not know how to eat to properly eat to manage their health conditions, and made poor choices as a result. D. Gana stated that only 2 providers in the area were funded for nutritional services.

K. Baron said that a registered dietician was available to provide medical nutrition therapy at her former employer. G. Grannan asked if a score of 8 in the essential health benefit factor specified categories that weren't funded by Ryan White. N. Johns responded that it did not. She said that it meant the service was required to be funded by private insurance, according to the Affordable Care Act (ACA). G. Grannan asked if the service was provided by private grants. N. Johns stated that it was likely that there were local organizations that provided the

[5] 215-985-2437

service. K. Baron said that some neighborhoods may have nutritional services available, but others might not.

G. Keys stated that her organization had nutritionists on staff. She said that many clients did not access the service. She noted that appointments were often canceled. K. Baron said that nutritional counseling appointments were prioritized below medical appointments for many people.

Vote: 7 members voted 5, and 3 members voted 1 on the community conscience factor for the nutritional services category.

Oral Health Care
K. Baron noted that the oral health category had scores of 8 in many of the factors. She pointed out that unmet need for the category was high. G. Keys said she was surprised that oral health care was not an essential health benefit. She noted that poor oral health was a risk to general health. K. Baron stated that oral health care could be very expensive.

G. Grannan said that many service categories had scores of 1s or 3s in the care continuum factor. He stated that this may reflect the system not prioritizing some services that could need to be prioritized. For instance, he said clients could be linked to oral health care at the point of diagnosis but currently are not.

M. Cappuccilli stated that oral health care patients had to be in medical care before they could access oral health care services. He said that they had to provide CD4 counts for confirmatory and safety purposes. G. Keys stated that providers had to have paperwork to administer many services.

Vote: 4 members voted 5, and 8 members voted 1 on the community conscience factor for the oral health care service category.

Psychosocial Support Services
N. Johns read the definition of the service category from PCN 16-02[6]. K. Baron reviewed scores for the service category across each of the first four factors.

D. Gana said he felt that organizations were doing well with providing support groups. However, he stated that some groups had low attendance. K. Baron added that some people were invited to support groups who did not attend. D. Gana said he felt the need for support groups was being met. K. Baron stated that people may not want to attend support groups

[6] Psychosocial Support Services provide group or individual support and counseling services to assist eligible people living with HIV to address behavioral and physical health concerns. These services may include:
• Bereavement counseling
• Caregiver/respite support (RWHAP Part D)
• Child abuse and neglect counseling
• HIV support groups
• Nutrition counseling provided by a non-registered dietitian (see Medical Nutrition Therapy Services)
• Pastoral care/counseling services

because of stigma. D. Gana noted that people may worry their status would be revealed if they attended a support group in the first place.

G. Keys asked if respite care was available to allow caregivers to attend support groups. N. Johns replied that it was not.

Vote: 1 member voted 5, and 11 members voted 1 on the community conscience factor for the psychosocial support services category.

Rehabilitation Care
N. Johns read the definition of the service category from PCN 16-02[7]. K. Baron reviewed the scores in the first four factors for the service category.

Vote: 11 members voted 1 on the community conscience factor for the rehabilitation care service category.

Substance Abuse Treatment (Residential)
N. Johns stated that this category referred to inpatient substance abuse treatment. K. Baron reviewed the scores for the service category in each of the first 4 factors. N. Johns noted that residential and outpatient substance abuse treatment were combined for the purposes of the consumer survey.

N. Johns stated that a new residential substance abuse treatment facility had opened in Chester with 50 beds. K. Baron said that many businesses providing substance use treatment had sprung up across the country. G. Grannan explained that the treatment industry was not well-regulated. He said that care provided by Ryan White should not be contingent on a client accessing substance use treatment.

Vote: 12 members voted 1 on the community conscience factor for the substance abuse treatment (residential) category.

Substance Abuse Treatment (Outpatient)
G. Grannan stated that data was available demonstrating the effectiveness of outpatient substance use treatment. He said that outpatient treatment included medication-assisted therapies (MAT). He explained that some people in the treatment community were not supportive of MAT, which could be a barrier to treatment. He noted that some recovery programs expressed prejudices against treatments that may help clients. Therefore, there was stigma against MAT and a bias toward residential treatment programs.

G. Grannan stated that it was important clients have transportation to outpatient treatment, which was often difficult in suburban areas. N. Johns noted that there was no treatment access point in Chester County except for the police station. G. Grannan asked how police referred clients to care who came seeking substance use treatment. N. Johns replied that anyone who was seeking substance use treatment was screened for outstanding warrants

[7] Rehabilitation Services are provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care.

before being referred to treatment. K. Baron said this seemed like a potential barrier to treatment.

Vote: 11 members voted 1 on the community conscience factor for the substance abuse treatment (outpatient) service category.

Translation and Interpretation
K. Baron read scores for the service on the first four factors. She noted that unmet need scores may be low because people who needed the service may be unable to report that need. N. Johns stated that Ryan White providers were required to provide translation and interpretation, though it was not always provided sufficiently. D. Gana said that translation and interpretation services for Spanish were often available, but they were not available for other languages.

M. Coleman asked if only health centers were required to have translation available, or if other organizations had to as well. He stated that lack of interpretation services could create a language barrier. G. Keys said that her organization had no interpreters on site for some languages, though they were available for hire. She said that hiring outside interpreters could present some logistical issues. G. Grannan stated that it was difficult to provide translation over the phone. He noted that children sometimes had to act as interpreters for their families.

J. Browne reported that translation and interpretation was supported through Part B.

C. Steib said that agencies should be asked to provide translated literature if they were not already doing so.

Vote: 2 members voted 5, and 10 members voted 1 on the community conscience factor for the translation and interpretation service category.

Transportation
K. Baron reviewed the category's scores in the first four factors. N. Johns noted that many open-ended responses on the consumer survey mentioned transportation. M. Cappuccilli said that availability of the service varied between different counties of the EMA. N. Johns stated that clients reported a need for transportation in all areas of the county. She noted that problems were commonly reported with Medicaid transportation, and the availability of transportation was restricted. She said that SEPTA transfers sometimes required $1, which many people could not pay. C. Steib said that some providers gave out tokens. N. Johns stated that clients receiving Medicaid were supposed to use that transportation first before accessing Ryan White. She said that transportation was an important way to make sure people got to their doctors.

C. Steib said it was uncertain how Ryan White transportation would be provided when SEPTA stopped accepting tokens. B. Morgan stated that this change had been discussed for a long time, but the specifics would be uncertain until the new SEPTA key system was completely implemented. G. Grannan stated that there was a market for tokens that was currently operating underground, and it was unknown what impact the shift would have on it. C. Steib noted that the new SEPTA payment system was currently being rolled out.

N. Johns stated that she did not think the true need for transportation was captured by the first 4 priority setting factors. She said it was the second most common item that respondents to the consumer survey mentioned as a barrier to their healthcare.

G. Grannan stated that some issues with transportation in Philadelphia were provider-based. He noted that Ryan White did not have authority over Logisticare. N. Johns stated that Ryan White transportation could provide a workaround to address barriers to transportation.

Vote: 11 members voted 5 on the community conscience factor for the transportation service category.

Treatment Adherence

N. Johns stated that treatment adherence was no longer its own service category. J. Browne said that the service was included in the medical case management and medical care service categories. M. Cappuccilli asked why this category was still considered in priority setting. N. Johns said it was a sub-service of other categories.

N. Johns read the definition of medical case management (including treatment adherence) from PCN 16-02[8]. B. Morgan said the unit of service was sessions. G. Grannan said that contact time with clinicians or case managers was being counted as treatment adherence whether or not they were adherent to their medications. He said he'd assume treatment adherence was measured by the amount of medication dispensed. N. Johns read the units of service that counted under the category as listed in the PCN.

K. Baron read off the scores for the category in the first four factors.

Vote: 1 member voted 5, and 10 members voted 1 on the community conscience factor for the treatment adherence service category.

[8] Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

B. Morgan sorted the categories in order, according to their scores on all 5 factors. K. Baron noted that medical case management was ranked below non-medical case management. N. Johns stated that the definitions of the service categories had changed. She explained that non-medical case management was used to help clients access services, whereas medical case management had to be connected to specific health outcomes.

M. Cappuccilli asked when allocations meeting dates would be set. N. Johns replied that allocations meetings could not be scheduled until the Ryan White grant total had been received. B. Morgan stated that, after federal Ryan White totals were set, HRSA, under the Department of Health and Human Services (HHS), made decisions about the total funding each EMA would receive.

K. Baron said she felt the priority ranking was accurate. J. Browne stated that AACO was in the process of developing a new medical case management model. M. Cappuccilli asked when the model would be rolled out. J. Browne stated that the Request for Proposal (RFP) would come out in the fall for the grant year. M. Cappuccilli said the Comprehensive Planning Committee had discussed bringing up the model in allocations. K. Baron stated that allocations could be modified based on emerging needs or changes.

Motion: G. Keys moved, J. Murdock seconded to approve the priority order as set and present it to the Planning Council for a vote. **Motion passed**: 12 in favor, 0 opposed, 0 abstained.

Old Business: None.

New Business: None.

Next Steps: K. Baron said the group would bring the priority ranking to the Planning Council at their next meeting for a vote.

Announcements: D. Gana said there was a sign-up available for a bus to the New York City Pride march next Sunday, June 25th. He said anyone who was interested should contact ACT UP. He stated that the bus would be leaving at 8am Sunday morning from Broad and Walnut.

Motion: L. Way moved, J. Murdock seconded to adjourn the meeting at 3:51p.m. **Motion passed:** All in favor.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- May 18, 2017 Meeting Minutes
- Insurance Status by Service Category from 2016 PDE Data
- Priority Setting Worksheet 2017
- Consumer Survey Question 38
- Unmet need data for Priority Setting 2017

- Care Continuum
- Consumer Survey Question 57
- OHP Calendar