Philadelphia HIV Integrated Planning Council
Comprehensive Planning & Needs Assessment Committees
Meeting Minutes
Thursday, April 20, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA

Present: David Gana, Ann Ricksecker, Adam Thompson, Gerry Keys, Nicole Miller, Jeanette Murdock, Joseph Roderick, Leroy Way, Mark Coleman

Excused: Katelyn Baron, Keith Carter, Karen Coleman, Lupe Diaz, Peter Houle, Lorrita Wellington, Cheryl Dennis, Tessa Fox, Pamela Gorman

Guests: Carla Fields, Jessica Browne (AACO), Sebastian Branca (AACO)

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

Call to Order/Introductions: A. Thompson called the meeting to order at 2:05p.m. Those present then introduced themselves.

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

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

Report of Staff: N. Johns noted that the online consumer survey had closed on Monday. She stated that some paper surveys were still being received. She noted that data entry for the survey would be completed by the end of April. She asked the group to encourage anyone who still had the survey to mail it in.

Report of Chair: No report.

Special Presentation:

- **Service Category Definitions and Utilization** – *Jessica Browne, AACO*

J. Browne noted that she worked in the AACO Information Services Unit (ISU). She stated that, in today's presentation, she'd provide descriptions for service categories funded under Ryan White Part A in the EMA. She added that she'd also describe how services were implemented in the EMA, along with the impacts of HRSA's Policy Clarification Notice (PCN) 16-02.

J. Browne pointed the group to a handout listing a taxonomy of service categories. She stated that she'd only be discussing services covered by Part A. She noted that she'd also distributed the text of PCN 16-02.

J. Browne provided background on PCN 16-02. She stated that it was released last fall and went into effect on 03/01/17. She explained that the PCN provided clarification on eligible

individuals, allowable uses of funds, and service category descriptions and program guidance. She said that changes from PCN 16-02 were listed in purple on the slides.

J. Browne stated that 13 services were currently funded in the EMA: 7 core services and 6 support services.

J. Browne began by describing AIDS Pharmaceutical Assistance[1]: local (funded under Ryan White Parts A and B) and community pharmaceutical assistance services (Part C and D). She stated that local pharmaceutical assistance provided medications to clients when there was a waitlist for ADAP. She noted that the PCN mandated that the local pharmaceutical assistance couldn't be used for emergency financial assistance. She explained that the service was offered in the Philadelphia EMA by 1 provider and one unit of service was defined as a 30-day supply of a prescription.

J. Browne distinguished between medical and non-medical case management. She stated that the goal of medical case management was to improve health outcomes, whereas the goal of non-medical case management was to improve access to services. She stated that medical case management had the goal of moving clients along the care continuum.

J. Browne defined medical case management. She noted that, under PCN 16-02, treatment adherence no longer existed as a separate funded category. She listed the key activities of medical case management. She noted that client assessment and the creation of a care plan were two important responsibilities of medical case managers.

J. Browne stated that, in the EMA, there were providers that were co-located with medical sites as well as CBOs that were not connected to medical sites. She noted that each approach had its own strengths and challenges. She said that AACO had recently convened a workgroup, and, based on feedback from medical case managers (MCMs), some recommendations had been made that were incorporated in the upcoming request for proposals (RFP). C. Fields asked if the workgroup that formulated these recommendations included consumers. J. Browne noted that the workgroup had concluded, but focus groups were currently being held to get as much input as possible. S. Branca said the workgroup had been very comprehensive. He noted that a series of focus groups would be happening rapidly. C. Fields asked how focus group enrollment was done. S. Branca stated that he'd look into it and provide more information. J. Browne pointed out that the process of needs assessment was currently in progress. S. Branca stated that the feedback would allow for more flexibility at CBOs and medical sites.

J. Browne stated that 22 agencies currently provided MCM in the EMA. She noted that one unit for MCM was equal to 15 minutes of service.

J. Browne reviewed the definition of medical nutrition therapy. She noted that 2 providers offered the service in the EMA.

[1] Complete service category definitions are included in handouts distributed at the meeting. The handouts are included in the scanned meeting packets and available on the hivphilly website.

J. Browne read the definition of mental health services. She noted that the PCN clarified that the service was only offered for PLWHA and not family members. She reported that 9 sites currently provided mental health services.

J. Browne stated that oral health care services were offered by 6 total providers in the EMA. S. Branca stated that some of these agencies were reimbursed for the services they provided.

J. Browne explained that outpatient/ambulatory health care had been renamed to outpatient/ambulatory health services by PCN 16-02. C. Fields asked what the service category meant. J. Browne stated that the category was for medical care. She explained that it included healthcare services provided by a licensed healthcare provider, consistent with Ryan White guidelines.

J. Browne stated that 26 providers in the EMA offered outpatient/ambulatory health services. She said that there were many types of providers that offered this service. She stated that one unit of service was equal to one medical visit.

J. Browne said that the last of the core services was substance abuse services. She read the service definition. She noted PCN 16-02 specified that syringe access services could now be funded under Ryan White. C. Fields asked if Narcan could be funded under RW. S. Branca stated that it could not. A. Ricksecker stated that Narcan was funded using a different source. S. Branca explained that there was a great deal of emphasis on Narcan access currently.

J. Browne read the definition for the first support service, emergency financial assistance. She stated that the PCN clarified that emergency financial assistance was paid to agencies and not directly to clients. She added that it was the payer of last resort, and for limited amounts, uses, and periods of time.

J. Browne reviewed the definition of food bank/home delivered meals. She stated that PCN 16-02 clarified that certain items (e.g. pet food) could not be provided under food bank/home delivered meals. She stated that the service was offered by 9 providers in the EMA.

J. Browne stated that Ryan White did not provide physical housing. She clarified that Ryan White housing was a limited, short-term service that included emergency rental assistance, transitional group housing, and legal support related to housing matters. She noted that housing programs were required to assist clients in staying in medical care. C. Fields noted that certain individuals needed housing even more than others. She asked if these individuals were prioritized for housing services. S. Branca asked if C. Fields was referring to housing through the Housing Opportunities for People with AIDS (HOPWA) program. C. Fields replied that she was not.

C. Fields noted that case managers did not always submit paperwork for housing or know the requirements for Direct Emergency Financial Assistance (DEFA). She stated that people who had particular housing needs were prioritized for DEFA. She suggested that AACO do more advertising about DEFA. J. Browne stated that medical case managers were expected to share information about DEFA with clients. S. Branca noted that, in the past 2 years, restrictions for DEFA had been relaxed. He stated that DEFA funding was limited. Therefore, there was an elaborate system for qualifying for DEFA. C. Fields said she had experienced a 3 month wait for DEFA. S. Branca replied that there should never be a 3 month wait. He stated that a

program had been implemented to monitor DEFA and identify any problems in service delivery. He noted that there had been increased utilization of the DEFA service following relaxations on restrictions. He encouraged clients with any issues with DEFA to provide feedback through the AACO Client Services Unit (CSU).

J. Browne stated that PCN 16-02 clarified that new clients must have access to housing services. She added that DEFA funding could not be in the form of direct cash payments and could not be used for mortgage payments.

J. Browne reviewed the definition of Ryan White medical transportation. She stated that this category referred to non-emergency transportation to core medical and support services. She noted that the program was the payer of last resort. Therefore clients had to go through other programs like Logisticare first. She noted that the service was currently offered by 4 providers in the EMA. She stated that transportation included bus passes, tokens, and taxi vouchers. She said that transportation was also available for medical case managers who were taking clients to appointments.

C. Fields stated that she was unable to use Logisticare because she was unable to climb steps to enter the Logisticare vehicle. S. Branca stated that Ryan White transportation should be allowable if Logisticare would not take a client. He asked if C. Fields was able to use public transportation. C. Fields replied that she was, depending on the location of the bus stop. S. Branca suggested speaking with J. Browne after the meeting about service delivery issues. J. Browne said her contact information was listed in the slides.

A. Ricksecker noted that the CPC had reviewed Medicaid transportation services in the past. She stated that the need for transportation varied among different areas of the EMA. N. Johns reported that transportation had come up frequently in the consumer survey. She stated that it was a frequent barrier to care. S. Branca stated that there were a limited number of tokens in Ryan White agencies. He stated that the Ryan White program had been flexible in its transportation services, especially considering some issues with Logisticare services. C. Fields stated that it would be helpful to speak with Logisticare representatives in a meeting. S. Branca said it had been difficult to make contact with Logisticare representatives. N. Johns noted that there were similar issues with Logisticare in other areas. She stated that the complaint process was unclear. C. Fields said that Logisticare was not used in some other states. S. Branca stated that Logisticare was supposed to have services for people who were non-ambulatory. C. Fields explained that she'd found Logisticare drivers unhelpful. A. Ricksecker noted that Ryan White had very little control over Logisticare. She stated that Ryan White should pay for transportation when Logisticare was not providing satisfactory services.

M. Ross-Russell stated that Logisticare was provided to clients with Medicaid, and was the first payer they turned to. A. Thompson stated that he'd heard of one area that used Uber for client transportation. J. Murdock explained that bus drivers did not help clients to get on the bus for liability reasons. She said that only clients who used walkers or wheelchairs were assisted on the bus, but drivers were not allowed to touch other clients. C. Fields stated that patients who experienced seizures should also receive special assistance. S. Branca said that agencies should provide tokens to clients who could not take Logisticare. C. Fields stated that she was sometimes not able to take SEPTA. S. Branca said that some agencies offered staff

transportation. J. Murdock stated that case managers sometimes sent accompanying individuals to take clients to the doctor.

J. Browne noted that "other professional services" was a new category. She stated that legal services were now under this category. She noted that the service included provision of legal services related to a client's HIV care and support, including assistance with benefits, power of attorney, and living wills. She stated that the service could provide ongoing assistance to clients. She stated that one provider in the EMA offered legal assistance through other professional services. A. Ricksecker asked what other services were included in this category aside from legal services. S. Branca replied that more were listed in PCN 16-02.

J. Browne reviewed the category of referral for health care and support services. She noted that the service directed clients to needed core medical or supportive services. She stated that 3 providers offered this service in the EMA, including the AACO CSU. She said that the CSU operated a helpline that provided information and referrals to clients in the EMA. She offered her contact information and a link to the PCN[2].

A. Ricksecker asked if behavioral health counselors were now covered under the mental health category. She noted that RW Part A had provided funding to help with a local program had previously been funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). S. Branca said this program had been transferred to Ryan White. A. Ricksecker asked who used local pharmaceutical assistance in the EMA. J. Browne stated that local pharmaceutical assistance was available when there was restricted formulary for the Special Pharmaceutical Benefits Program (SPBP), a waiting period, or financial barriers. A. Ricksecker noted that the EMA currently met none of these conditions. S. Branca stated that the previous local pharmaceutical assistance program in the EMA had been moved to DEFA. He noted that the health centers had on-site pharmaceutical assistance programs. M. Ross-Russell stated that local pharmaceutical assistance could not be utilized beyond a 90-day period.

A. Ricksecker stated that it was important to consider the emergency medication assistance programs during priority setting. She noted that the EMA did not fund psychosocial services. S. Branca stated that the category was funded under Part B. A. Ricksecker noted that services that were not provided by licensed clinicians in the EMA were not funded. She stated that the Planning Council did not have sufficient knowledge of what services were funded by Part B. N. Johns noted that priority setting was intended to rank the needs of all PLWHA in the EMA. M. Ross-Russell stated that information about other payers was taken into account during allocations. S. Branca noted that the taxonomy in the handouts demonstrated what services were paid for by other sources.

A. Thompson asked if the numbers of programs that provided the service, as listed in the slides, included only providers that were funded through Part A. S. Branca confirmed. A community member noted that her medical care was too expensive due to copays and out-of-pocket expenses. S. Branca asked the individual if they went to a provider that used a sliding scale payment schedule. He noted that these providers may be charging more. A. Thompson

[2] https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf

noted that there was an annual cap for how much RW providers were able to charge out of pocket per year. The individual noted that they'd lost some Medicare benefits.

A. Ricksecker noted that the presentation had discussed services that were currently covered under Part A. She noted that the Comprehensive Planning Committee had recently been discussing health insurance premium/cost-sharing assistance.

Discussion Items:

- **Care Continuum Tool Review**

A. Thompson noted that the group would be discussing the process for priority setting. He directed participants to the care continuum tool in their packets. N. Johns stated that the continuum tool was used as a factor in priority setting. She directed the group to the factors included in their packets. She invited the group to consider whether they wanted to update or change the continuum tool. She noted that she'd changed "legal services" to "other professional services," in accordance with changes made in PCN 16-02. She stated that she'd left treatment adherence on the continuum, even though it was no longer its own funded service.

N. Johns explained that services listed in blue were core services, which received the bulk of Ryan White Part A funding. She stated that the orange bars represented support services. She stated that there had been discussion of moving housing and legal services further left on the continuum. A. Ricksecker noted that moving the bar on the graph was significant, as the care continuum factor counted for 20% of the total score. A. Thompson asked if "housing" on the continuum referred to Ryan White housing. He noted that this would make a difference in the continuum. N. Johns said the group could view housing as Ryan White housing or any other variety, at their discretion.

A. Ricksecker noted that substance use providers commonly tested for and diagnosed HIV. She stated that this may be a justification to move the substance use services bar on the continuum. A. Thompson clarified that the group had decided to move the other professional services category on the continuum, and they were also considering shifting substance use services. A. Ricksecker asked if there was anything in DEFA that related to linkage to care. A. Thompson noted that funding for medication gaps was very important early in care.

M. Ross-Russell stated that harm reduction could be related to linkage to care. C. Fields stated that PrEP access was important for HIV-negative partners of people living with HIV. N. Johns said that the legislation specified that beneficiaries of Ryan White programs must be HIV-positive. A. Ricksecker stated that health education and risk reduction was a category that promoted safer sex, so it stretched across the continuum. She said that PrEP education was included in this category. She stated that health education and risk reduction could be prioritized highly. She noted that the category was not currently funded through Part A. N. Johns said it was funded under Part B.

C. Fields asked if PrEP could only be provided at HIV service organizations. A. Thompson replied that this was untrue, though PrEP was often available at these providers. M. Ross-Russell noted that Ryan White would not fund PrEP, and this had been made clearer recently.

A. Thompson stated that he'd heard the suggestion of moving DEFA and other professional further left on the continuum to linked to care. C. Fields noted that substance use services were funded by other payers. A. Thompson noted that priority setting did not directly relate to which services got money. He stated that substance use services were not covered by the Department of Behavioral Health (DBH) outside of Philadelphia. He noted that outpatient substance use treatment was prioritized highly because the service was useful. He said the group was considering if the service category helped with diagnosis. A. Ricksecker stated that she was fine with it not being moved. She agreed that moving DEFA and other professional services made sense. A. Thompson asked if treatment adherence should be removed because it was no longer a service category of its own. M. Ross-Russell noted that early intervention services had also been moved on the continuum.

A. Thompson asked if there was opposition to moving DEFA and "other professional services" over to "linked to care." No one expressed any opposition.

- **Review of Scoresheet Tool**

N. Johns displayed a demonstration priority setting scoresheet on the projector. She stated that members were able to vote on the service rankings as part of the community conscience factor. A. Thompson asked the group if they were okay with the objective factors being prepopulated on the scoresheet, and then they would spend a bulk of their discussion on voting and determining the community conscience factor. A. Ricksecker asked if the objective data could all be measured. N. Johns stated that it could. She noted that the essential health benefit factor had not changed. She added that the other data was either known or would be available by priority setting. She stated that 378 consumer surveys had been received, which would be updated in the data. A. Ricksecker stated that the service categories that had been changed along the continuum should be updated on the score sheet.

M. Ross-Russell noted that she had not changed the rankings on the sample scoresheet. N. Johns noted that some service categories would not be mentioned in the unmet need factor. M. Ross-Russell stated that services that were not funded may not be available, which would skew data.

A. Thompson said the group would present the process to the Planning Council next month for voting. He encouraged all Comprehensive Planning Committee members to attend the meeting.

N. Johns noted that service utilization data by income and insurance status was included in today's packets. She stated that AACO representatives had provided this data. She said this information could be used to inform the community conscience factor and/or future discussions. She suggested looking at the data and examining regional differences.

Action Item:

- **Finalize Priority Setting Factor Definitions, Weights and Scores**

N. Johns reviewed the factors that had been discussed at the last meeting. She stated that it was important to define the community conscience factor. She said that, if the group could not finish this work today, they could move priority setting to June and continue the discussion next month.

A. Thompson said he'd been debriefed on priority setting since the Comprehensive Planning Committee last meeting. He stated that the group had discussed using the factor to identify emergent needs that had not been pinpointed by the data. He said the factor was also intended to include vulnerable populations. He asked the group if they'd like to propose other criteria to consider in making this decision other than data.

A. Ricksecker stated that the consumer survey was the main representative factor of consumer need. N. Johns noted that CSU data on needs was also used. She acknowledged that the consumer survey tended to capture people who were already in care. However, she said CSU data tended to capture individuals who were just entering care. She added that Medical Monitoring Project (MMP) data was used, and it included people who were and were not in care. She stated that the data sources were intended to gauge different angles on consumer need. N. Johns stated that the consumer conscience factor may capture emergent need in a way that the other factors did not. She said that some of this might be captured through the open-ended questions on the consumer survey.

M. Ross-Russell noted that some service needs and gaps were anecdotally shared very frequently but were not clearly reflected in the data. A. Ricksecker stated that some needs and feedback were difficult to measure numerically. A. Thompson said the factor touched on lived experience. M. Ross-Russell noted that translation and interpretation services were not reported on English-language surveys. She said that few Spanish surveys had been received. She noted that many Spanish speakers who did take the survey noted a need for this service, but the need was not well-represented in the data. She said that this disparity demonstrated a need to capture more qualitative feedback.

C. Fields said that some clients had believed the consumer survey was required to receive services. M. Ross-Russell stated that some individuals may have had that experience, but they were not reflective of the entirety of people who took the survey. She explained that a wide range of surveys had been received back with valuable input. C. Fields said that PLWHA may not be participating in priority setting in large numbers. A. Thompson stated that many people who participated in meetings were HIV-positive. He stated that the community conscience factor was intended to add to available data. A. Ricksecker stated that vulnerable populations like undocumented people and transgender people could be represented by the community conscience factor. She said that vulnerable populations could be considered as broadly as possible.

N. Johns suggested that the committee review the four sub-factors they'd previously discussed (e.g. vulnerable populations). She stated that they had talked about reviewing each service category and determining which of the sub-factors it addressed in order to determine if it received a score of 1, 3, 5, or 8. She added the assigned scores could also be reviewed after they were determined by the CPC and then the Planning Council. A. Thompson proposed that the sub-factors include emergent issues, vulnerable populations, service utilization, and community experience. He said the Positive Committee would have an important role in the process.

M. Ross-Russell suggested assigning the scores of 1, 3, 5, and 8 depending on which categories were fulfilled by each service. A. Ricksecker stated that the numerical system may be overly restrictive. A. Thompson stated that the 4 sub-factors could drive the discussion.

A. Ricksecker stated that she had written "not so worried" for 1 and "worried" for 8. She suggested dividing up the 4 sub-factors in a similar way to capture subjective views. M. Ross-Russell stated that the group may have to consider future policy changes in their conversation as well. N. Johns stated that a number 1 could be assigned to denote a neutral response on a service category. She said that the amount of "worry" would increase with each value. M. Ross-Russell stated that the sub-factors like "emergent issues" would drive discussion. N. Johns suggested taking into account the way need was represented by other factors in determining the numbers that were assigned. A. Thompson suggested the following breakdown for the numerical assignments: 1 was neutral, 8 meant that community need and concern was underrepresented by other factors, and 5 was somewhere in the middle.

N. Johns stated that, if approved, she'd update the factors following today's discussion and present them at the Planning Council meeting.

Motion: A. Ricksecker moved, D. Gana seconded to approve the factors as outlined in the meeting (25% Consumer Survey, 20% Care Continuum, 30% Unmet Need, 10% Essential Health Benefit, 15% Community Conscience). **Motion passed**: the CPC agreed to approve the factors by general consensus.

Old Business: None.

New Business: A. Ricksecker asked if the group had received any additional information from the state in response to their recent letter about health insurance premium/cost-sharing assistance (HIPCSA). A. Thompson said they had received a response. M. Ross-Russell replied that they had not received additional information beyond the initial response. She said that the state would discuss how they'd work out a HIPCSA program in collaboration with the EMA.

Next Steps: N. Johns stated that the priority setting factors would be presented at the next Planning Council meeting for discussion and voting. She noted that priority setting would be carried out at the CPC meeting in May.

Announcements: None.

Adjournment: The meeting was adjourned by general consensus at 4:06p.m.

Respectfully submitted by,

Jennifer Hayes, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- March 16, 2017 Meeting Minutes
- RWHAP Services and PCN 16-02 (Slides)
- Service Category Definitions
- Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds (PCN 16-02)
- Priority Setting Care Continuum Tool

- Service Priority Setting Worksheet 2017
- Consumer Survey Question 38, Preliminary Results
- 2016 AACO Service Utilization Data
- OHP Calendar