

MEETING AGENDA

VIRTUAL:

Thursday May 19, 2022

2:00 p.m. – 4:00 p.m.

- Call to Order

- Welcome/Introductions

- Approval of Agenda

- Approval of Minutes (*April 21, 2022*)

- Report of Co-Chairs

- Report of Staff

- Discussion Item
 - Priority Setting Process

- Other Business

- Announcements

- Adjournment

Comprehensive Planning Committee

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**Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, April 21, 2022
2:00-4:00 p.m.**

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

Present: Keith Carter, Debra D'Alessandro, Gus Grannan (Co-Chair), Pam Gorman, Gerry Keys, Marilyn Martinez, Hemi Park

Guest: Michael Baldino-Kelly

Staff: Beth Celeste, Sofia Moletteri, Mari Ross-Russell, Elijah Summers

Call to Order: G. Grannan called the meeting to order at 2:04pm

Approval of Agenda: G. Grannan presented the April agenda for approval. **Motion:** **G. Keys motioned, K. Carter seconded to approve the April 2022 agenda. Motion passed: 2 in favor, 2 abstain.**

Approval of Minutes (March 17, 2022): G. Grannan presented the previous meeting's minutes for approval. **Motion: G. Keys motioned, K. Carter seconded to approve the March 2022 meeting minutes. Motion passed: 2 in favor, 2 abstained.**

Report of Co-Chairs:

No Report.

Report of Staff:

No Report.

Discussion Items:

–Priority Setting Process–

S. Moletteri reported that there were nine service categories to vote on at this meeting. After this meeting there would be seventeen service categories left. Key consideration information from the last meeting such as the new transmission data, the increase of new HIV diagnosis of people who inject drugs, were presented as a refresher the group. S. Moletteri reported that there was also information on the service definitions and consumer survey data. The key consideration part of each service category also included language from the program guidance.

K. Carter asked if for next month's meeting if the committee could receive the service categories, considerations, etc. prior to the meeting? S. Moletteri responded yes. She then reported that the nine categories the committee was voting on today were Local Pharmaceutical Assistance Program, Mental Health, Medical and Nutritional Therapy,

Substance Use, Outpatient Treatment, Early Intervention Services, Home Health Care, Home Health Care, and Community Health Care, Hospice Services, and DEFA.

S. Moletteri reported that for each service category they would read the service definition and stated they would use relevant data from 2017's community survey as a reference to see how the landscape may have changed. Additionally, the "Worth Noting" section was derived from EPI data, AACO presentations, etc. The goal was to not talk about allocations and dollars, and to keep this about priorities because priority setting would inform allocations later this year. S. Moletteri reported that the voting scale was one, five, or eight. One signified that it was not a priority for vulnerable populations and not an emergent need. Five represented critical and was an emergent need. Eight represented it was a priority and was going to be the most needed for vulnerable populations.

S. Moletteri reported that the Local Pharmaceutical Assistance Program (LPAP) was a supplement to provide ongoing medication assistance. When HRSA, Ryan White, ADAP, etc. have restricted formulary waiting lists and/or restricted financial eligibility criteria. It has to follow 340B requirements. Recipients must have record keeping, an advisory board, a distribution system, high enrollment and rescreening at least every six months, and coordination with Part B ADAP. According to consumer survey data from 2017, 28% of people use SPBP/ ADAP to get their medications. Medicare Part D accounted for 34%, Patient Assistance was 7% of respondents, other insurance was 7% of respondents, and 5% of people paid by themselves. S. Moletteri reported that LPAP funds were not to be used for emergency or short-term financial system assistance similar to EFA. Approximately 80% of Ryan White clients have insurance and 65% are covered under Medicaid/ Medicare. Utilization has decreased because of increased efficiency with the SPBP program.

G. Grannan asked regarding the requirement for a record keeping system for medications, if the state PDAP was being used for that? M. Ross-Russell answered the record keeping responsibility would fall to the Recipient and subrecipients. Anyone who utilized the service would have to report on each individual service anyway. She stated that information was reported by the individual provider to the Recipient if they were funded to provide local pharmaceutical assistance. Lastly, every provider has to collect a degree of information for every service that was provided, and it has to be reported back to the Recipient.

G. Grannan asked if they were running a separate system or were they running reports on the State's PDAP and submitting them to AACO? M. Ross-Russell answered that to the best of her knowledge that was not the case, G. Grannan was talking about Walgreens as one of the primary sources of this as well as the health centers providing these services. There were funded FQHCs that also have pharmacies that would have to provide this service. S. Moletteri asked if there was any discussion around the key considerations, the "worth noting" section about 65 being covered under Medicaid/Medicare or SPBP?

K. Carter stated that this category was declining in utilization because as the system improved more people received access to this service, so it was not necessarily a negative that it was under utilized. G. Keys agreed that it had a positive aspect. D. D'Alessandro added that Pennsylvania has one of the most generous SPBP formularies in the country. People were able to utilize SPBP if what they had was not covered by their other insurance for various

medications. G. Grannan responded that it appeared that a lot of people who would normally be covered by Ryan White were covered by some other payment means, which people have said was great. G. Grannan stated that as a committee they had to make sure that anyone who needed medication had as few barriers as possible to receive proper care given the amount of reliance there was on clinical care, both in the National HIV Strategy and in the EHE program.

K. Carter stated that they're doing an excellent job of coming up with ideas and strategies to help case managers get access to drugs for their clients. G. Grannan added the reductions coming from a shortening of the prescription was a great place to reduce expenditures. S. Moletteri reported that the committee voted and three people voted not critical or a 1, one critical or 5, and one priority-need or an 8.

S. Moletteri reported that the next service category was Mental Health services, or the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services offered to clients living with HIV. They were based on a treatment plan and conducted in an outpatient group, or individual sessions were provided by a mental health professional, licensed or authorized within the state to render such services. Such professionals typically included psychiatrists, psychologists, and licensed clinical social workers based on the consumer data. About 63.5% of respondents have reported being diagnosed with at least one mental health disorder. 31% reported actually using the service and less than 10% reported needing it, but not being able to receive the service.

S. Moletteri reported in the "Worth Noting" section that depression and anxiety were estimated to be fairly common among people living with HIV. According to the American Psychiatric Association, 20% to 40% of people living with HIV are estimated to suffer from depression. During a presentation provided to the HIPC, K. Moore said he had done his own research within two organizations and that percentage was 50%. While 55% of respondents to the said that they would screen positive for depression. In his presentation he stated that this might have been higher because of stigma and people simply do not realize that they were actually suffering from depression.

K. Carter asked if it was possible to get people connected to mental health services outside of the current system by using a telehealth service? A lot of people do need mental health services, there weren't enough providers and there was a waiting list for available mental health providers. M. Ross-Russell stated that due to the success of telehealth during the COVID-19 pandemic things have changed significantly, so it was probably here to stay. G. Keys stated that these services were definitely needed, but there were also many therapists that do not take insurance; therefore, so many people cannot take advantage of their services. Some therapists were self-pay and the cost started at \$100-150 per session. M. Baldino-Kelly stated as a representative of the Recipient that they went back to look at who was providing which mental health services and through what changed since the COVID-19 pandemic and it has changed significantly. There has been an increase in the mental health services via telehealth due to their accessibility.

M. Ross-Russell reported that there was always going to be a procurement process and having contracts and subcontracts with people or subrecipients. As G. Keys stated there may be providers that were restrictive to where their client may receive services and that left people with limited options. M. Ross-Russell stated that there had to be people available and that was also part of the ability to provide a service. D. D'Alessandro asked can these funds for Ryan White clients be used for clinical sites that have their own on-site behavioral health counselors? M. Ross-Russell answered that it depended on the individual contracts with the provider. S. Moletteri reported the results of the poll and four people listed Mental Health services as an 8 or a priority need, and one person listed it as a 5 or a critical need.

S. Moletteri reported that the next service category was Medical Nutrition Therapy and the key activities included nutrition assessment and screening, dietary nutritional evaluation, food and/or nutritional supplements, medical providers recommendation, education, and counseling. These activities could be provided in individual or group settings and outside of Ambulatory Health Services, which was the first service category. According to the 2017 community survey data, 10% of people reported needing this service, but not receiving it. A lot of respondents also report having comorbidities related to nutrition like high blood pressure, high cholesterol, and diabetes. All activities under this service must be pursuant to a medical provider's referral. Additionally, activities not provided by a registered licensed dietitian should be considered a psychosocial support service. The last consideration was that this was a service with increased need, as there was an aging population of people living with HIV within the Philadelphia EMA and it has been discussed during HIPC meetings.

K. Carter asked how many nutritionists were available in the Philadelphia EMA? He stated that he did not know where people received this service. G. Keys added that she did not think the majority that may need this particular service would utilize it or currently utilize the service. She stated that some of the clients in the health centers where nutrition services were available there were referrals made; however, the client would not go over and speak with them. People, especially those living with comorbidities, know that they need to change their diets, but it was difficult to change behavior. She thought it was needed, but not a high priority.

M. Martinez stated that where she worked they tried to hire more diverse nutritional providers. She stated that this has helped her clinic a bit because patients were more receptive to the service and utilized it more than once. She continued that they consciously noticed that patients who needed that service were saying that they were not getting it or did not think it was important. They did not prioritize it, so that would decline the service. M. Martinez reported that they provided focus groups where clients shared that they did not identify with a nutritionist which led them to hire three new staff members. M. Ross-Russell added that medical nutrition services were also billable under Medicaid.

M. Ross-Russell reported that part of the issue was that as the number of nutritional providers was also related to the amount of funding that was going into the category and allocations as opposed to the importance of the service. Those were two separate issues. M. Ross-Russell reported that if medical nutritional services or therapy was not funded in one of the regions, then it may not happen at all. If you only put in a certain amount then given the cost for the

provision of that service or hiring somebody to provide that service was where the issue began regarding the number of hours that could potentially be provided.

M. Martinez reported that for her patients who were living with comorbidities, it was important that the nutritionist was following the patient's goals. She stated that her clients were battling food disparity/ insecurity, and the nutritionists were keen to ensure that the patients were getting food delivered to their homes or had access to pantries that had the fresh food. She believed that medical nutritional therapy was a very strong pillar for the community that she served. K. Carter agreed it was important that people learned these healthy habits to improve their quality of life. S. Moletteri reported the results of the poll; one person voted it was not critical or 1, four people voted critical or 5, and one person named it a priority or 8.

S. Moletteri reported the next service category was Substance Abuse Treatment which included outpatient activities such as screening, assessment, diagnosis, and/or treatment of substance use disorder including pre-treatment, recovery readiness programs, harm reduction, behavioral health counseling associated with substance use disorder, outpatient drug-free treatment and counseling, medication assisted therapy MIT, neuropsychiatric pharmaceuticals, and relapse prevention. S. Moletteri reported that according to the Community survey data from 2017, 9% of respondents needed this, but did not receive this service and 13% used it in the last 12 months, and 10% reported being diagnosed with substance use disorder. According to the program guidance, acupuncture therapy may be allowable under this service category if included in the documented plan; additionally, syringe access services were allowed. Substance use was estimated to be fairly common among people living with HIV. S. Moletteri cited K. Moore's presentation to HIPC because that was both about mental health and substance use. He said that 24% of people living with HIV were in need of substance use treatment. This was according to data from the CDC; however, the number was much higher in one of his studies that he did which reported 80% and 75% respectively screened positive for previous substance use. He cited the War on Drugs as a possibility behind disparities, due to lack of trust in reporting back honest responses regarding drug use.

G. Grannan asked if the syringe services included syringe access programs? M. Ross-Russell answered that they did not provide syringes to consumers. She continued by saying when talking about a program that provides syringes, it was the support of the actual program and not the apparatus itself. D. D'Alessandro reported that the CDC has a page on federal funding for syringe service programs that cited the Appropriations Act. Under certain circumstances it supported syringe service programs with the exception of funds that may not be used to purchase needles or syringes, but it doesn't specifically say anything about other drug paraphernalia at present.

D. D'Alessandro theorized that the low percentage of people saying they needed this program, but did not get the treatment was a reflection of the fact that the Community survey may not have reached more people who were in that category. G. Grannan responded that people out of care's percentages might look different. Part of the reason may also be that people may not feel confident depending on the program they were participating in and people calling up to administer surveys over the phone to disclose such personal information. M. Ross-Russell reiterated that this was not a phone survey. The community survey was a paper survey or

could be completed online. She continued that OHP staff do not have access to consumers in our office, so the office was dependent on providers for distributing the survey tool. Finally, as part of the process, we asked them to distribute it even to those individuals who may be lost to care. M. Ross-Russell reported that there were some periodic contradictions with the data, but it was only as good as the providers who were willing to participate in the process and distribute the surveys. As well as doing their due diligence to post the information so that people can actually take the survey and respond. M. Ross-Russell reported the NHBS data for people who inject drugs that those numbers have increased. S. Moletteri reported the results of the poll; three people voted it as a priority need, or an eight and two people voted it as a critical need or a five.

S. Moletteri reported that the next category was Prevention Services. This was a combination of services; rather than standalone services like the other ones which included early intervention activities such as accessing linkage, education, targeted HIV testing, and referral services to improve HIV care and treatment at the points of entry. S. Moletteri shared that it was worth noting that there was no Community survey data to share, but HIV testing paid by early intervention cannot supplant testing efforts paid by other sources, as per usual, and this was in the key considerations that were discussed in the last meeting. There was a 151% increase in new HIV diagnoses for people who inject drugs between 2016 and 2019. There's been a gradual increase throughout each of the years and 63% of EMA diagnoses were in Philadelphia.

S. Moletteri reported that within the new HIV diagnoses of people who inject drugs the largest share were men, Black individuals, Hispanic individuals, those over 40, and men who have sex with men that were more likely to be diagnosed late. It was estimated that about 10% of people living with HIV within Philadelphia were unaware of their status and that 10% accounts for almost 40% of new transmissions. The further along a consumer was within the care continuum, that transmission rate decreased and that was due in part to early interventions.

K. Carter asked if this service included using emergency PrEP services? M. Martinez answered that PrEP was definitely an early intervention service; however, under Ryan White programs PrEP was not considered early intervention, that money would come from the 340B which was a different grant. M. Ross-Russell agreed and reported that PrEP was considered a prevention service and it was funded under the CDC. The Ryan White HIV/AIDS program funds were for those individuals who were people living with HIV. Early Intervention services were usually provided in the case where providers believed that somebody was at high risk for transmission. S. Moletteri shared the results of the poll; two people rated it as critical or a 5 and three people named it a priority or an 8.

S. Moletteri reported that the next service category was Home Health Care and activities provided must relate to the client's HIV status and may include administration of prescribed therapeutics, preventative and specialty care, wound care, routine diagnostic testing administered in the home or other medical therapies. According to the program guidance, this was limited to clients that were homebound, this did not include inpatient care for mental health or substance use treatment facilities. S. Moletteri reported that according to the

community survey data from 2017, 11% of people surveyed reported using the service in the last 12 months while another 11% reported needing the service, but not being able to receive it. Once again, this may be a service with increased need as a population of people living with HIV ages. Considering that over half of the EMAs people living with HIV were over 50 years old. According to 2020/2021 combined CSU data, home health care was the least requested service.

D. D'Alessandro asked for a definition of "homebound" in this case. G. Keys answered that it meant ambulatory care. G. Keys reported that for home health care providers, they did not see a great need for this as it pertained to people's HIV status. Years ago there was a great need for this service, but presently it was more of chronic illnesses that were not related to HIV. She stated that she believed it was not a high priority. G. Grannan stated that it did not seem like these numbers would have changed too much in the last few years. G. Keys stated that she had not seen a great need from her clientele, but did not know what other practices have experienced in the EMA. K. Carter asked if this service was covered under Medicaid or Medicare? M. Martinez answered that it was her understanding that Home Health Care was covered for the other chronic diseases and was covered by most insurances like Medicare and Medicaid. Additionally, she agreed with G. Keys that there was not an increase in need in the Home Health Care service category. M. Martinez reported that in her practice she saw that Home Health Care was utilized by people with comorbidities and other conditions.

M. Ross-Russell reported that a part of the confusion associated with this service was that there were two very similar things: Home Health Care and Home and Community Based Health Care. The former of which was provided generally by a nurse and the latter which was provided by a nurse's assistant or a position that doesn't require the same higher level of nursing care or treatment. This supported both what G. Keys and M. Martinez stated because people were living longer and healthier lives. S. Moletteri shared the results of the poll where everyone agreed it was a 1 or not critical.

S. Moletteri reported as M. Ross-Russell stated that Home Health Care and Community Based Health services were very similar. The key activities included appropriate mental health, developmental and rehab services, day treatment or other partial hospitalization services, durable medical equipment, home health aide services, and personal care services in the home. The community survey data between the two services were very similar except community based was 1% higher of people reporting needing the service in the last four months and these are the same key considerations that Philadelphia has an aging population of people living with HIV. G. Grannan asked if the durable medical equipment included not only the purchase, but the cost of maintenance and upkeep? M. Ross-Russell answered that she did not have the information at this time. S. Moletteri shared the results of the poll; five members answered that it was not critical and voted it as a 1.

S. Moletteri reported the next category was Hospice Services and services were only accessible to clients in the terminal stage of HIV related illness. Similar to the Home Health Services category, it has to be HIV related. Allowable services were mental health counseling, nursing care, palliative therapeutics, physician services, and room and board. S. Moletteri reported that program guidance for this was provided in-home or other residential settings that

do not extend to skilled nursing facilities or nursing homes. There was no previous community survey data associated with this service category. G. Grannan asked if OHP had the data on the increased lifespan of people living with HIV and was there data on causes of death of someone who lived with HIV? What were the chances of them dying from complications related to HIV versus having a stroke? G. Keys answered that she believed the likelihood of dying from complications related to HIV was more likely than stroke. G. Grannan stated that in the 90s there were a lot more patients dying of complications related to other chronic diseases like heart disease or cancer. This was also an outcome of the illness. He asked if this category would cover someone in their 70s and been living with HIV for a long time and was one of the earliest patients in the AZT trials and that altered their body that may not have been fatal at the time, but over the course of 30-40 years and living with the effects of early medicine? M. Ross-Russell answered that some information related to this question could be found within the surveillance report that's posted on phila.gov, that was produced by the Health Department. HIV related deaths were recorded and the data was as recent as 2019. It contained the information and percentage of HIV related deaths among all individuals who had a positive HIV status. M. Ross-Russell reported that reviewing differences in gender, race, ethnicity, age, HIV diagnosis, and transmission risk was information available on their website. Lastly, the percentages were based on the total number of deaths in a calendar year among people who were living with HIV at the time and all of these percentages were very low. S. Moletteri shared the results of the poll; everyone voted it as a one or low priority.

S. Moletteri reported the last service was DEFA or Direct Emergency Financial Assistance, it provided limited one-time or short-term payments and they can be direct cash payments with urgent need for essential items or services necessary to improve health outcomes including utilities housing, food (including groceries and food vouchers), transportation medication not covered by ADAP, pharmaceutical assistance, or other HRSA/ Ryan White allowable costs that were needed to improve health outcomes. S. Moletteri reported that it would not cover anything related to paying a mortgage because it was a rent and utility based payment. DEFA must occur as a direct payment to an agency or through a voucher program. S. Moletteri reported that according to community survey data from 2017, 11% of respondents reported using this service in the last 12 months and 17% reported needing the service, but not being able to get it as housing costs and housing insecurity were an added burden for people living with HIV. S. Moletteri presented data regarding the PLWH within the Philadelphia EMA who were at or below 100% of the federal poverty level which was approximately \$12,590 per person. This accounted for 50% of MSM who were also PLWH, 45% of people who inject drugs, 47% of heterosexuals, and 61% of Transgender individuals which are the most housing insecure population, especially Transwomen. M. Martinez stated that she believed these numbers were much higher now due to COVID-19 because people lost their jobs, insurance, etc. and this program helped people remain in housing who faced eviction. M. Martinez reiterated to the committee that this was a very important service category with demonstrable need. S. Moletteri shared the results of the poll; everyone voted it an 8 or a priority.

Other Business:

None.

Announcements:

None.

Adjournment:

G. Grannan asked for a motion to adjourn. D. D'Alessandro motioned to adjourn. K. Carter seconded the motion. The meeting was adjourned at 3:57 p.m.

Respectfully submitted,

Elijah Sumners

Materials Included:

IHAP Checklist

Priority Setting Presentation

Key Considerations

DRAFT