Ryan White Planning Council (RWPC) of the Philadelphia Part A (Title I) EMA
Comprehensive Planning Committees
Meeting Minutes of
Wednesday, December 2, 2009
10:00 a.m. – 12:00 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Christine Ambrose, John Churchville, Karen Coleman (Co-Chair), Michael Myers, Ann Ricksecker (Co-Chair)

Excused: Alicia Beatty, Marcelo Fernandez-Vina, Peter Houle, Sandra Thompson

Guests: Joyce Collins (AACO), M. Bradley Shannon (AACO), Evelyn Torres (AACO)

Staff: Aneeza Agha, Monica Getahun, Briana Morgan, Mari Ross-Russell

Call to Order/Introductions:
K. Coleman called the meeting to order at 10:15 a.m. All those present then introduced themselves.

Approval of Agenda:
K. Coleman presented the agenda for approval. **Motion:** J. Churchville moved, C. Ambrose seconded to approve the agenda. **Motion passed:** All in favor.

Approval of Minutes *(16 November 2009)***:**
K. Coleman presented the November 16, 2009 minutes for approval and briefly reviewed the previous meeting for the benefit of those present. **Motion:** J. Churchville moved, C. Ambrose seconded to approve the November 16, 2009 minutes. **Motion passed**: All in favor.

Report of Staff:
None.

Report of Co-Chair:
A. Ricksecker stated that it was important for committee members to notify staff if they were unable to attend a meeting. J. Churchville and C. Ambrose stated that they had had difficulty receiving emails. B. Morgan replied that she would review the email list and verify the information with the committee members.

K. Coleman stated that her term as co-chair would be ending, and that the committee could feel free to look to new leadership. J. Churchville and C. Ambrose replied that they would like to keep K. Coleman on as committee co-chair.

Discussion Item:
- **Client Services Unit Update**

RYAN WHITE TITLE I PLANNING COUNCIL (RWPC)
Comprehensive Planning Committee
Meeting Agenda
Wednesday, December 2, 2009 10:00 a.m. - 12:00 p.m.
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

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Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Chair

Discussion Items

- Client Services Unit update

Old Business

- Recapping the Priority Setting conversation

New Business

Announcements

Adjournment

PLEASE TURN ALL CELL PHONES AND PAGERS TO SILENT OR VIBRATE.

The next meeting of the Comprehensive Planning Committee is ***Wednesday, January 6, 2010, 10am – 12pm*** *at 340 N. 12th Street, Suite 203, Philadelphia, PA 19107.* ***Please refer to the Office of HIV Planning calendar of events for committee meetings & updates (www.hivphilly.org). If you require any special assistance, please contact the office at least 5 days in advance.***

Ryan White Planning Council (RWPC) of the Philadelphia Part A (Title I) EMA
Comprehensive Planning Committees
Meeting Minutes of
Wednesday, November 16, 2009
10:00 a.m. – 12:00 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Christine Ambrose, Alicia Beatty, John Churchville, Karen Coleman (Co-Chair), Marcelo Fernandez-Viña, Tom McCoy, Mike Myers, Ann Ricksecker (Co-Chair), Sandra Thompson, Jacqueline Whitfield

Absent: Peter Houle

Guests: Ronald Lassiter, Anthony Santella (via conference call), Coleman Terrell (AACO)

Staff: Monica Getahun, Nicole Johns, Briana Morgan, Michael Milsop, Mari Ross-Russell

Call to Order/Introductions:
K. Coleman called the meeting to order at 10:09 a.m. All those present then introduced themselves.

Approval of Agenda:
A. Ricksecker presented the agenda for approval, noting that they were meeting to discuss their Priority Setting exercise. <u>**Motion:** C. Ambrose moved, S. Thompson seconded to approve the agenda. **Motion passed:** All in favor.</u>

Approval of Minutes *(7 October 2009)***:**
A. Ricksecker presented the October 7, 2009 minutes for approval and thanked those who had attended the October meeting for their work on the Working Goals & Objectives. <u>**Motion:** C. Ambrose moved, S. Thompson seconded to approve the October 7, 2009 minutes. **Motion passed**: All in favor.</u>

Report of Staff:
None.

Report of Co-Chair:
None.

Discussion Item:
- **Priority Setting Exercise**

A. Ricksecker stated that the top author, Anthony Santella, from the "Developing and Implementing a User-Friendly Priority Setting Tool" presentation *(see – attached slides)* would be joining them by conference call at 10:30 a.m. She explained that the Comprehensive Planning Committee had based their previous years' priority setting tool on what they had learned from this presentation. She went on to direct those present to review the slides with particular attention to p. 4, which showed that New York City has a specific committee to deal only with Priority Setting & Resource Allocation. She then asked those present to review p. 6, asking the group what stood out. C. Terrell pointed out the validity checks, and A. Ricksecker added that they form an advisory panel. A. Beatty then asked how many people were on the advisory panel. A. Ricksecker replied that she believed it consisted of twenty-five members, but that they would ask for that information on the conference call. C. Ambrose stated that she would be interested in what Quality Management Data they looked at. M. Milsop explained that they have a specific type of handout that they use, which he then passed around the room *(see – attached handout)*. A. Ricksecker stated that New York City compiles all data onto two pages for each service category.

A. Ricksecker redirected the group's attention to the slides on p. 7. M. Milsop noted that the committee had followed the 2005-2007 Priority Setting Process the previous year. The group then moved on to review the 2008 Priority Setting Process. A. Ricksecker noted that they had moved to a 100-point scale in 2008 *(see – attached handout)*. M. Ross-Russell explained that New York had decided that a 100-point scale would be easier for those involved to understand. She went on to say that they had changed the weights for the factors to percentages that would add up to 100%. She noted that the only time they had used a score of zero was for supportive services in the core service category. She next explained that they had switched to an eight-point scale because of studies that had been done on scoring scales, noting that this would also give them a wider spread on the scoring. She then added that a consultant had been hired to work specifically on their Priority Setting process. She noted that the group had also used an Excel spreadsheet for scoring, and that the group had reached a consensus on the scores for each factor. A. Ricksecker stated that it was important to consider that New York chose to reach a consensus. M. Ross-Russell added that the group had agreed to disagree and respect all opinions, and that they began the discussion by talking about the reasoning behind the most common score in the group. She went on to say that this helped the group to capture the reasoning behind their scoring.

A. Ricksecker asked about the PC '09 Rank column, as it did not match the total percentage. She went on to say that it was possible that was the previous year's rank, which they would use when looking at the 2010 rank. She noted that they could ask about this on the conference call.

C. Terrell pointed out that New York City only prioritizes categories that they actually fund, which would be a consideration for the group. M. Ross-Russell noted that New York City also had a staff person call each provider to find out what alternate sources of funding were available, which had been a long and drawn-out process. She went on to say that New York City also has an excellent public health system, which was a consideration to make.

A. Ricksecker asked those present to return to reviewing the slides. She noted that K. Coleman had asked if it would be possible for A. Santella to review the slides with the group. M. Ross-Russell replied that he had previously done this with her. She noted that New York City would leave the priorities as listed for three years, and that they would only go back and revisit them in the case of drastic funding changes. She added that they run Priority Setting and Allocations separately, and that they only use the priorities when they experience funding cuts.

A. Ricksecker suggested using their time on the conference call for information gathering, without talking about what their Planning Council had been doing. She went on to say that they would have to do a check-in at the end of the meeting, and think about whether or not they would be making changes to their own process. She asked the group if they would like to vote on changes in the current meeting, wait to hear from the RWPC, or vote on any possible changes at their next meeting. K. Coleman suggested waiting to make changes until they had the opportunity to present the information to the RWPC. A. Ricksecker asked for staff input. M. Milsop replied that they had been telling the RWPC that this meeting would be a listening session, and that making changes during the current meeting would be inconsistent with what they had previously said. J. Churchville agreed that they should think about what they hear today rather than making changes in the current meeting. M. Myers added that what worked for New York City might not fit with the Philadelphia EMA, and that they might change their minds about certain things that had worked for New York City.

A. Santella was then put on speakerphone with the committee. A. Ricksecker introduced herself and the committee, noting that the group had several handouts in regard to the New York process. She then stated that she and K. Coleman had both attended his presentation. A. Santella asked if they would like him to walk through the tool. A. Ricksecker agreed, and reviewed the handouts the group had before them. She noted that she would use the slides to frame the questions.

A. Santella stated that he had been with the Health Department for two years, and that the tool they had used two years ago was very difficult to understand. He explained that the first task he had when working for the Planning Council was to streamline the Priority Setting and Resource Allocation processes. He went on to say that he had spent about two months reworking the tool with the Planning Council's permission, looking at what other tools existed. He noted that there were not many Ryan White-specific tools out there, although he had found tools for prevention. He pointed out that there were many more restrictions to work around with Part A funding than prevention. He explained that the tool that he started to work with was used in the Midwest in the Education Department, and that this tool was very easy to explain and user-friendly. With their permission, he combined this with the previous tool used in NYC to create what the group had before them. He noted that the previous tool had similar components, but the scoring system was very complicated. He stated that the highest score on the old tool would be 58.5, which was difficult for people to conceptualize. He explained that there had been no rules attached to the scoring process, and there were a great deal of service categories all clumped together. He noted that at the end of the day, everyone thought that everything was very important, so adding rules helped them to really assess the priorities. He explained that he had taken the key components from the old tool, improved the scoring, and then created the current tool. He noted that he left the weights open for discussion, and they had been using this new tool for the past two years. He stated that they had determined that the results of tool would be valid for three years, since things did not change dramatically each year, and they would make minor tweaks each year. He added that they had added money to food bank this year since the need had gone up. He went on to say that it was important to note that this tool was only used for Priority Setting, and that Resource Allocation was done separately.

C. Ambrose then asked if they changed the scores along with the allocations if there were changes. A. Santella explained that they would change the score for special cases once each year, and that the Allocations are separate and not related to the scores. He went on to say that they only use the Priority Setting tool when services are tied. He noted that they had a separate tool for Resource Allocation, and they carry over dollar amounts year by year, which he would be looking at revising in the fall. He went on to say that it was so hard to develop accurate cost information, so they would look at the Priority Setting tool only if they received a cut in funding. He noted that in the event of a large decrease, they had a separate tool that they would use to create proportionate decreases based on the scores. A. Ricksecker stated that they had Priority Setting vs. Allocations discussions, and that the Finance Committee supports the Allocations process and the Comprehensive Planning Committee supports the Priority Setting process. A. Santella explained that they have a separate Priority Setting & Resource Allocation (PSRA) Committee, and the Finance Committee meets quarterly with no hand in Allocations. He noted that any decisions made by the PRSA committee would first go through the Executive Committee, then the full RWPC.

K. Coleman asked for more information about compiling a program budget. A. Santella said that the program budget was the Ryan White budget, noting that it was important to have a budget before using the tool. He noted that they have subcategories within certain service categories, but they clump them all together for the purpose of Priority Setting. A. Ricksecker asked for more information about the advisory panel. A. Santella replied that this would be the PSRA committee. A. Ricksecker then asked for more information about the validity checks with the stakeholders. A. Santella replied that they have about twenty members on the PSRA committee, and that they always have representatives from the public coming to advocate for their respective committees. He noted that their checkpoint would be the Executive Committee, which was made up of the chairs of all committees. He stated that the tool would then go through the full RWPC, which would be a second checkpoint.

A. Santella next explained that the process had taken a total of ten to twelve hours in 2008, not counting the homework done by the committee. He stated that the committee members had gone over data before the meeting, and that they had handouts containing data at the meeting as well. A. Ricksecker asked about the group coming to consensus on scoring for service categories. A. Santella replied that the group would review the data and score 3-4 service categories per meeting. He then stated that he would ask the group to complete the tool by themselves before the meeting, and that the group would discuss the results at their meeting. He noted that they would have a 15-20 minute time limit for discussion on each service category, and they would vote on scoring for each factor. He explained that if there was a tie, they would re-vote and then move on. C. Ambrose asked PRSA committee members were the only ones to score the service categories. A. Santella agreed, noting that the meetings were open to everyone, but they would only allow members of the committee to vote. K. Coleman asked how long the process takes. A. Santella replied that they typically begin in April, and finish by the beginning of June. He noted that the Executive Committee would vote on the priorities at the end of June, and that the RWPC would vote on them in July. He added that July was the end of their cycle, and that the RWPC took two months off until October.

A. Santella then began to walk the group through the tool, beginning with the instructions *(see – attached handout)*. He pointed out the definitions for the factors listed at the bottom of the sheet. He noted that CHAIN was a specific source of data, which was available on the website. He explained that this involved a three hour interview, which provided them with more in-depth information. He pointed out that they had had some complaints from consumers that surveys were being filled out by providers, so they had been conducting focus groups for the past two years. He went on to say that they held five focus groups with ten participants in 2008, and that they had done about 12 focus groups during 2009 to help them with data for Priority Setting. He noted that specific gaps/emerging needs was a difficult factor to quantify, but they had mostly used epidemiological data and surveillance reports for this category. He pointed out that the core service category scores were pre-populated before discussing the categories as a committee. He noted that services could score 0, 1, 3, 5, or 8, pointing out that 0 was only used for non-core services. He stated that skipping from 5 to 8 allowed them to have a larger variation between scores for the categories, and that they had rules that no more than 5 8's should be given to one factor or to one category. He pointed out that they did break that rule once, in the access to and/or maintenance in care factor. He then stated that they had chosen the weights assigned to the factors as a committee, and that the group had begun by ranking the factors in order of importance. Once the group had them in order, they worked the percentages out to add up to 100%. He noted that they had wanted round numbers for the percentages to make the tool easier to understand. He went on to say that they then looked at the service categories, and that they completed this in a drop-down cell on an Excel spreadsheet. He pointed out that if there was a tie between two scores with the group, they would re-vote between those two scores.

A. Ricksecker asked what they did with new service categories that had no history. A. Santella replied that youth outreach was one such case, and that they had used the best information available at the time. He stated that they had had HOPWA data for this, and some basic information about what the program would entail. He noted that this program could get completely rescored the next year once they had more information. He explained that there had been many community members at these meetings, and that while they listened to what those in the community had to say, it was difficult to evaluate data that they got on the spot. He added that they also ensured that everyone disclosed their conflicts of interest. C. Ambrose asked about health insurance premium/cost-sharing assistance as a new category in the Philadelphia EMA, and asked if it was funded under another service category in New York City. A. Santella replied that they do not fund that category, but they might look at ADAP for relevant data.

A. Ricksecker asked if they had thought about changing the factors, or adding new factors. A. Santella replied that he had proposed adding a new factor, but the committee had decided against it. He stated that these criteria were the same as the old ones. C. Ambrose asked if they used utilization data in any of these factors. A. Santella replied that the score cards for each service category were developed mostly from utilization data. M. Milsop clarified that service utilization data was not used as its own factor. A. Santella agreed, noting that service utilization was typically represented in specific gaps/emerging needs. He stated that they look at trends over the years, demographics of those served, utilization data, and additional data. He added that they would use the current year's funding to break ties between service categories.

A. Santella next explained that ambulatory care did not truly have a score of 2, but that this category had a special situation in New York state. He stated that ambulatory care benefitted from the score of ADAP Plus, and that they keep these two categories together. A. Ricksecker asked for information about ADAP Plus. A. Santella replied that ADAP Plus is essentially outpatient/ambulatory medical care, and that such a high proportion of PLWHA in New York state live in NYC that the state supports them through this category. He noted that they do not fund any outpatient medical care on its own. He explained that one change that might happen when they next revise the tool is scoring ADAP Plus and ambulatory care as one.

A. Santella explained that Resource Allocation occurs after they receive their funding award, and before they do Priority Setting. He stated that they used a similar tool for Allocations, where they can plug in a percentage cut that would show them how much money to take away from each service category in relation to their score. A. Ricksecker stated that they would like to see the Resource Allocation tool to share with the Finance Committee. A. Santella stated that they were currently working to create a reproducible tool because they had received a very large cut about five years prior, and they wanted to have a tool ready to deal with this type of situation in the future. He noted that they did have contingency plans for increases in funding as well. He went on to say that they wanted to reinvent Resource Allocations because the funding had been carried on from year to year to year, and they would like to look at everything again from scratch. He noted that they wanted to have health researchers conduct analyses on what programs are most cost-beneficial. A. Ricksecker stated that she would love to see any work on this. A. Santella replied that this would be presented at the next Grantee Meeting.

A. Ricksecker asked if A. Santella knew of other EMAs adopting a similar Priority Setting process. A. Santella replied that he had heard that Texas and North Carolina were thinking about using this tool. He went on to say that he had asked if HRSA had any similar tools to recommend, but they did not know anything about this type of tool. He noted that he had gotten a great deal of questions after the meeting, but that he was unsure who had implemented it. A. Ricksecker asked if they considered anything with

Part B in their tool. A. Santella replied that they do consider what the state contributes. A. Ricksecker asked if their EMA includes any other state. A. Santella replied that the EMA covered the five boroughs, and outside areas only comprised about 5% of the EMA, so they received about 5% of the award.

M. Milsop asked if they used the score card as a part of Allocations. A. Santella agreed, noting that they spent two three-hour meetings going over the score cards. He explained that they made sure that everyone understood the score cards so they were not rehashing everything when they scored the service categories. M. Milsop asked if "clients by special population" were determined by the RWPC. A. Santella replied that the Needs Assessment Committee had developed five special populations. He noted that the 50+ population was not listed under that category, but that information was contained elsewhere. M. Ross-Russell asked if the final tool they were using was the FY2010-11 tool. A. Santella agreed. M. Ross-Russell then clarified that the original tool was the 2005-2007 tool. A. Santella agreed, noting that the FY2010-11 tool was based off of the one used in 2008.

A. Ricksecker thanked A. Santella for speaking with the committee, and asked if he had any recommendations that he had not mentioned. A. Santella replied that it had helped to determine exactly what the tool would look like, what information would go into it, and other logistical information before doing any scoring. He stated that anyone that missed meetings would have to go back and review minutes and speak to staff, and that they would not go back and rehash anything that was previously discussed. He noted that they would have to also accept that they would not have perfect data. He went on to say that any new data would have to be vetted through the committee, and that it could not be introduced by one person at the last minute. He explained that time limits were also helpful. C. Ambrose stated that a big part of the issue was the learning curve and getting people to understand the new tool. A. Santella stated that they had dedicated an entire meeting to understanding the tool, and that he gave a talk on the tool at orientation, at a RWPC meeting, and before starting the process, so they heard about it three times. He went on to say that it also helped to explain the math with the entire group present.

A. Ricksecker stated that the group used a slightly different process from what he described in their first year, and it had radically changed the ranking order from what they had previously seen. A. Santella stated that they had had the committee members familiarize themselves with the math so they truly understood what was happening with the numbers. He went on to say that they had a wide range of backgrounds and education levels on their committee, so they ensured that they had full understanding from everyone participating in the process.

A. Ricksecker then thanked A. Santella again for the discussion, noting that it had been very helpful. The conference call then ended.

A. Ricksecker asked the group what they had learned from the conference call. A. Beatty stated that the structure of the committees was very different, and that the

Executive Committee was a new concept. She stated that the specific PSRA committee makes New York's process very different as well, which had jumped out as a major difference to her. C. Ambrose stated that New York also had the ability to have research projects do a great deal of the work. A. Ricksecker noted that there was a great deal of data that went into their consumer priority factor. K. Coleman noted that another difference was that the committee did a great deal of outside work, while their committee frequently relies on the staff to do a great deal of work. C. Terrell stated that the group consensus on scoring could make a big difference in the process, and that it was also probably helpful to not score all of the service categories in one meeting. A. Ricksecker agreed that it would be interesting to allot 15-20 minutes to each service category. M. Milsop replied that they had more service categories to consider, so they would need more meeting time. He noted that the consumer priority data would also be tricky, since they do not do the town halls until fairly late in the year. He added that it probably add consistency if they only allowed voting members to score the categories.

J. Churchville stated that New York's process was a little less democratic than their process. He went on to say that no one in the Philadelphia EMA could say that they did not have the opportunity to be heard. He stated that they were able to call people out when they did not participate. He went on to say that he had not heard anything that would cause him to deviate from their process. He noted that he did not think there was a difference between having the scores add up to 100% as compared to what they had used the previous year. He then stated that they should think very clearly and carefully about honing the process they had already used rather than making radical changes.

T. McCoy stated that New York City has richer involvement from consumers than Philadelphia. He went on to say that they needed to consider that they would have less consumer input in their own EMA. A. Ricksecker stated that New York City not only had a consumer committee, but they also had a Consumer Advisory Board. T. McCoy replied that this could be like the Positive Committee if they had people that were consistently attending and understanding the process. A. Ricksecker stated that an advisory board would typically serve a different function.

C. Terrell stated that they would also need to consider the timeline, since New York City only conducted the Priority Setting process every three years. He noted that they could use the town halls from the previous years, and they could start the process much earlier rather than waiting for all of the data to be brand new. M. Milsop replied that it was helpful to do the town halls yearly, and that they got great participation from a much larger geographical area. He explained that there was a difference between responses from people that would only go to meetings in a central location and the people in their local communities.

K. Coleman stated that it was interesting that the committee members discussed everything so much. A. Ricksecker stated that the score cards were excellent. She went on to say that they should feel very good about what they had accomplished in their priority setting process, and with further tweaking it could be even better. She noted that they could tighten up some variables, and that this would ultimately be a process that would be unique to their committee.

A. Ricksecker asked what the next steps would be. M. Milsop noted that they would be looking at the Client Services Unit data at their next meeting. A. Ricksecker suggested adding an agenda item at their next meeting where they would discuss the committee's report to the RWPC. She explained that they should tell people what they are thinking about before making actual decisions. She asked the group if they would like to pull out the recommendations that could alter their system at their next committee meeting. The group agreed that they would like to talk about this at their next meeting.

A. Ricksecker stated that the information that had come from Finance Committee was fantastic, and that they might consider that data when they decide to work on their own score cards. M. Ross-Russell noted that they already use much of the information on the score card, and that it is simply presented differently. She explained that the data is usually presented by type of data rather than by service category in the Philadelphia EMA.

Old Business:
None.

New Business:
None.

Announcements:
None.

Adjournment:
The meeting was adjourned at 12:03 p.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from October 7, 2009
- NYC HIV Health and Human Services Planning Council FY 2010-11 Priority Setting Tool
- Developing and Implementing a User-Friendly Priority Setting Tool Slides
- Questions for the Discussion
- NYC HIV Health and Human Services Planning Council FY2009 Priority Setting Tool
- Service Category Score Cards
- OHP Calendar

Philadelphia Department of Public Health

AIDS Activities Coordinating Office, Client Services Unit

December 2, 2009

The Client Services Unit (CSU)

- Intake services to HIV positive individuals requesting case management services
- Information and referral services for all other AACO funded programs
- Process individuals' requests for subsidized housing
- Feedback about funded providers
- Local and state-wide Case Management Coordination Project

CSU Mission

- Help HIV infected and at-risk individuals understand their needs and make informed decisions about possible solutions
- Advocate on behalf of those who need special support
- Reinforce clients' capacity for self-reliance and self-determination through
  - education
  - collaborative planning
  - problem solving

CSU Information

- Health Information Helpline is open 8 a.m. to 6 p.m. Monday– Friday
- **1-800-985-2437**
- Staff of thirteen
  - 1 Manager
  - 1SW Supervisor
  - 1Housing Supervisor
  - 5 City Social Workers
  - 2 Housing Staff
  - 1 I/R Specialist
  - 2 Training Coordinators (local & state)
- 5 staff speak Spanish, other interpretation handled through the City's language line

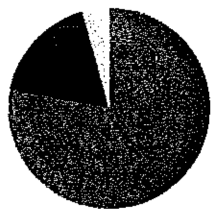
Intake Data

CM Intakes

- 1803 unduplicated clients CY 2008
- 1720 unduplicated clients CY 2007

Status Jan – Nov 2009		Gender CY 2008		Race/Ethnicity CY 2008	
Assigned/	1947/ 96%	Male/ **1172**	65%	Black/1204	67%
Declined/	9/4%	Female/ **609**	34%	White/264	15%
Lost to Care/	38/ 2%	Transgender/ **21**	1%	Hispanic/187	10%
Other/	35/ 2%			>1 race/140	8%
Waiting list/	73			Other/	2%

Income per the 2008 Federal Poverty Level



Insurance Status N=1803 Clients

Insurance status	
Medicaid	47%
No insurance	25%
Medicare	13%
Private	7%
Other public	5%
Unknown	1%
Other	2%

Client Needs CY 2008

Needs	Percent
Housing assistance	60%
Mental health	34%
Transportation	28%
Food bank/home delivered meals	25%
Medical insurance	23%
Medical care	19%

Needs	Percent
Medications	17%
Substance abuse	11%
Finance	11%
Legal	9%

MCM Follow-Up

Performance Measure	Data	3/07 - 2/08	3/08 - 2/09
Client referrals from the AIDS Activities Coordinating Office, CSU		1797	1983
Six-week follow-up form submission	Percent of forms submitted	97%	89%
	Target	95%	95%
Retained in HIV medical case management	Percent of clients retained in MCM	67%	78%
	Target	90%	90%
Retained in HIV medical care	Percent retained in HIV medical care	63%	72%
	Target	100%	100%

Medical Case Management

Why Medical Case Management

- Ryan White Treatment Modernization Act
  - Established core and supportive services
  - Mandated 75% of funding allocated to core services
  - Medical case management is a core service
  - Expanded the definition
    1. The coordination and follow-up of medical treatments is a component of medical case management
    2. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments

Benefits of Medical Case Management

- Engagement in HIV medical care is vital to the health of HIV clients
  - Improved survival
  - Decreased morbidity
  - Decreased transmission
  - Improvement in racial and socioeconomic disparities
- Ancillary services, such a case management, play a crucial role in improving linkage and retention in HIV medical care
  - ARTAS
  - HRSA

Mugavero, Michael J.
"Improving Engagement in HIV Care: What Can We Do?"

AACO Goals for MCM

- 100% of case management clients in HIV medical care
- Increase collaboration and communication between the medical and MCM providers
- Clearly define the role of the case manager
- Increase retention and follow-up of client's medical care by the case manager

AACO's Implementation Strategy

- Identify and solicit feedback from key stakeholders
- Internal AACO committee
  - Plan and implement MCM
  - Ongoing review of change process
- Extensive training and technical assistance
  - The Case Management Coordination Project in collaboration with the PA/MidAtlantic AIDS Education and Training Center

Stakeholders' Input

- AACO internal MCM Committee incorporated the information gathered from RFP, Case Managers and Consumer's surveys and other sources into:
  - Service provisions
  - Role & responsibilities of the medical case managers
  - Policies & procedures for MCM funded providers
  - Training

MCM Expectations

- Detailed in MCM Service Provisions
- Start date of 10/1/09
- Greater emphasis on:
  - Linkage and retention in HIV medical care and other medical treatments
  - Treatment adherence counseling
  - Health literacy

MCM Expectations

- Standard forms
  - Assessment
  - Service Care Plan
  - Medical flow sheet
- New service provisions for supervision of medical case managers
- Use of validated tools
  - Health literacy
  - Treatment adherence

Client Survey

- Anonymous Survey
  - Participants >18 years old, attended at least one MCM visit in past 12 months
- Goal of 600 clients
  1. Client's comfort level with their medical case manager's role in medical care
  2. The extent of medical case manager's involvement in client's medical care
  3. Level of client satisfaction with medical case management services

Client Survey
N= 314

Gender
- Male: 62%
- Female: 34%
- Transgender: 4.3%

Race/Ethnicity
- Black: 79%
- White: 9%
- Latino: 5%
- Other: 5%
- Am. Indian or Alaska Native 1%

Client Survey
N=314

- Client comfort with MCM
  - Percent who agree/strongly agree:
    1. 89% want case manager involved in HIV medical care
    2. 85% feel comfortable with case manager going to HIV medical visits
    3. 90% feel comfortable with case manager speaking to HIV medical provider
- Medical Case Management Activities
  - Percent reporting usually/always
    1. 82% report case manager follows up on medical appointment
    2. 67% report case manager discusses HIV medications
    3. 69% report case manager discusses risk reduction

Client Survey
N=314

- Percent who agree/ strongly agree
  - 96% feel case manager is comfortable with his/her race/ethnicity
  - 96% feel case manager treats him/her with respect
  - 93% are satisfied with case management services

Challenges to MCM

- MCM requires that medical case manager be familiar and comfortable with HIV disease and progression
- High case loads
- High turnover
- Collaboration between CBO/ASO's and medical providers

Information & Referral Data

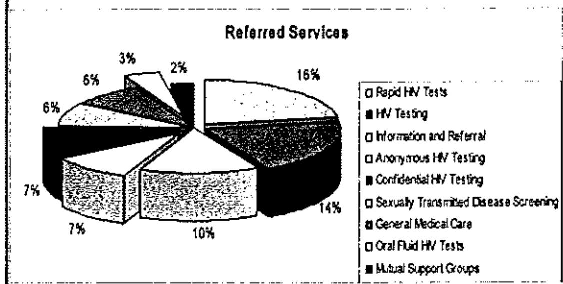
Information & Referral (I/R) Calls

- **354 calls 1/1/09 – 11/30/09**
- **596 calls 1/1/08 – 11/30/08**
- **928 calls 1/1/07 – 11/30/07**

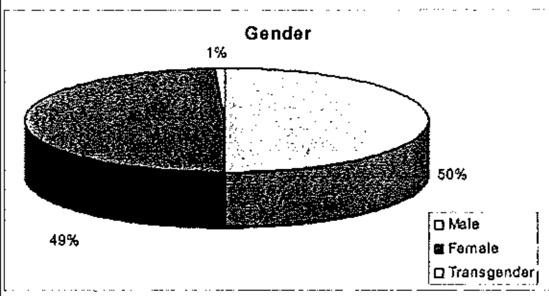
Referred services for 2009	# of calls referred	% of calls referred
Rapid HIV Testing	55	16%
HIV Testing	49	14%
Other hotlines	37	10%
Anonymous HIV Testing	24	7%
Confidential HIV Testing	24	7%
STD Screening	22	6%
Medical Care	20	6%
Oral Fluid HIV Testing	10	3%
Support Groups	7	2%

I/R Calls 2009

47% of calls are regarding HIV testing



I/R Calls 2009



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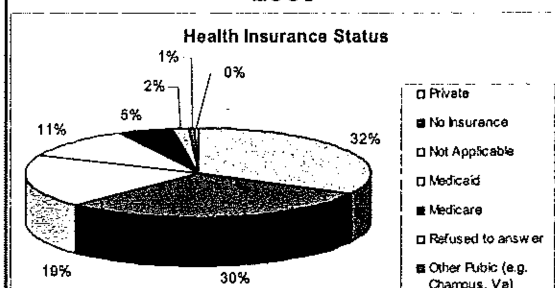

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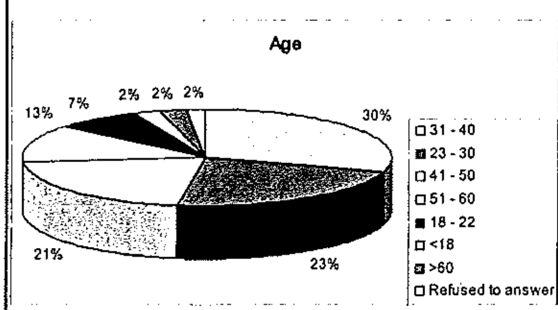

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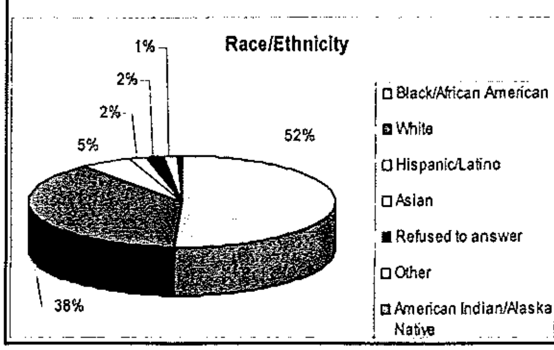

Housing Services Program (HSP)

What the HSP Does

- Centralized intake for applicants seeking **permanent** rental assistance (subsidized housing)
- The main referral source for housing sponsors providing Housing Opportunities for People With AIDS (HOPWA) or HIV/AIDS Shelter Plus Care (S+C) housing

What the HSP Does

- Process and evaluate individual applications for housing
- Maintain the waiting list
- Provide training to southeastern PA service providers
- Provide ongoing TA to providers
- All services at no cost
- Do not provide emergency housing

HSP Scope

- 7 housing sponsors
- 644 housing slots
  - Recent increase of 40 slots
  - 513 HOPWA
  - 131 S+C
- 89% tenant based
- 11% project based

Waiting List

- 195 applicants currently on the waiting list
  - 4 homeless
- Wait time up to twenty-two months
  - For homeless less than six months

HSP Criteria

- Medical criteria
  - Must have AIDS diagnosis or meet criteria for SSD specifically due to HIV
    - Defining criteria are shrinking
- Low income
  - $43,600 for single
    - 75% of applicants
  - $62,250 for family of 4

HSP Criteria

- Resident of southeastern PA
- Able to obtain utility services
- Active in case management
- Active in medical care

HSP Disqualifications

- Homeowner
- Already receiving subsidy
- Active D/A

HSP Funding

- The AACO Housing Services Program (HSP) is 100% funded by HUD
- Via the Philadelphia Office of Housing & Community Development (OHCD)
- The HSP receives $0 from Ryan White funds

Ryan White Funding

1. Objectives (quantifiable time-limited objectives related to the service priorities)	Allocated funds	Type
a: Provide emergency short-term rental assistance necessary to gain or maintain access to medical care	$298,138	DEFA
b: Provide support services for AIDS housing placements	$21,928	Housing Counseling
c: Provide transitional group residential housing for medically needy HIV+ persons	$203,921	Transitional Housing
d: To keep persons with HIV in safe, affordable housing by representing clients in housing courts and in negotiations with landlords to prevent evictions and stabilize living situations	$71,634	Legal Aid

HSP Breakdown

- Stats provided are for FY 09
- July 1, 2008 through June 30, 2009
- Total applications received – 236
  - Up 21% over FY 08
- Total referrals made for permanent placement – 90
  - Exactly the same as FY 08

HSP by Gender

Female	76	32.2%
Male	153	64.8%
Transgender	7	3%

HSP by Race & Ethnicity

Black / AA	176	74.6%
White	18	7.6%
Latino	29	12.3%
Multiracial	9	13.8%
Unidentified	3	1.3%

- Zero identified as: Alaskan Native, American Indian, Asian, Native Hawaiian, or Pacific Islander

HSP by D/A & MH

D/A	58	24.6%
MH	99	41.9%
Dual Dx	37	15.7%

HSP Applicants Source of Income

Child Support	0	0
DPW	57	24.2%
SNAP (FS)	101	42.8%
Employment	29	12.3%
SSD	72	30.5%
SSI	103	43.6%
Retirement, VA, Other, & unknown	5	2.0%

Grievance Process

- 30 complaints filed in 2008
- Services
  - DEFA
  - Case Management
  - Housing
- Agencies are required to have internal grievance process

Case Management Coordination Project

- Yearly training and certification for Ryan White Part A/B funded case managers and case management supervisors
- New case managers and their supervisors are required to complete core requirements
- Once the core requirements are completed, they must obtain at least twenty hours of continuing education training each year, including six hours related to HIV disease
- The local project is in collaboration with the local AIDS Education and Training Center

A. Ricksecker stated that this presentation would provide data that the group would later use in Priority Setting. E. Torres began to review the Client Services Unit (CSU) presentation *(see – attached slides)*, including basic information about the CSU and its mission. She introduced J. Collins as the CSU supervisor and M.B. Shannon as the housing supervisor. She then noted that there were five Spanish-speaking staff members.

E. Torres next reviewed the demographic information for case management intake. She noted that 73 people were currently on the waiting list, which was exclusive to Philadelphia. She then explained that some clients want to go to one specific case management agency and are willing to wait. She went on to say emergency cases and the homeless are eligible for immediate intake. She continued on to review income levels, insurance status, and client needs in case management intake. K. Coleman asked if housing assistance under client needs referred to help paying rent or help in attaining housing. E. Torres replied that this typically concerns consumers seeking rent assistance under DEFA. A. Ricksecker asked for more information about the “finance” category under client needs. E. Torres replied that this was typically in reference to benefits, and that it usually involved a referral to case management. K. Coleman asked if any clients had identified needing help with co-pays. E. Torres replied that she did not have that information. J. Collins stated that they had had a few calls from consumers that could not afford their co-pays.

E. Torres stated that Philadelphia was operating under a medical case management model, so they conducted medical case management follow-up. She explained that CSU sends out a questionnaire six weeks after intake asking whether a client was retained in medical case management and medical care. She noted that retention in medical case management had increased from 67% to 78%, and retention in medical care had increased from 63% to 72%. She added that they also follow up after one year. A. Ricksecker asked if medical care retention was self-reported. E. Torres replied that they obtained this information from the case management provider. A. Ricksecker asked if they became involved with those that had been lost to care. E. Torres replied that she could not speak to the involvement of the case manager, but that CSU is not involved after the survey. She went on to say that it is the responsibility of the provider receiving funding for care outreach to follow up with the consumer. C. Ambrose stated that they would want to do care outreach with those that did not make it into care in the first place as well. E. Torres agreed, noting that care outreach was designed for medical care rather than medical case management.

E. Torres then moved on to review the reasoning behind using a medical case management model. C. Ambrose stated that the new expanded definition strongly emphasized care outreach. E. Torres agreed. She then moved on to review the benefits of medical case management, explaining that this model helps clients to live longer, healthier lives. She next reviewed AACO’s goals for medical case management, pointing out that they had been tracking linkage to medical care since 2001. She continued on to review the medical case management expectations, which now included asking women if they were getting screened for cervical cancer.

E. Torres next reviewed the results from the client survey, which had been used to help understand clients' reactions to the medical case management model. She explained that they attended various meetings for a convenience sample, and that they currently had 450 surveys. She noted that they had only begun in July, and that they currently had data for 314 of their surveys. She went on to say that 48% of those interviewed said that they had not been involved with case management for more than seven years, and then reviewed the other results from the survey. She then stated that they had also done a case management survey, and learned that case managers are less comfortable with more concrete activities, like treatment adherence. A. Ricksecker stated that the Needs Assessment Committee uses a great deal of consumer information throughout the year, and that this survey would be a helpful addition. E. Torres agreed, noting that M. Ross-Russell had already requested this information.

E. Torres moved on to discuss the challenges associated with a medical case management model. She stated that this was a very intensive model, so high case loads presented a challenge. She went on to say that there were also logistical issues involved in the collaboration between medical providers and CBO/ASOs. A Ricksecker asked if medical case management was reimbursable in PA. E. Torres replied that a provider could be reimbursed for HIV case management through the Department of Welfare, with a great deal of restrictions. She noted that there was a very low reimbursement rate, and the HMO had to make the organization a part of the provider network. A. Ricksecker stated that they had discussed similar issues in regard to dental care, noting that some funded providers would not take MA. She asked how much AACO encourages providers to seek HMO reimbursement. E. Torres replied that this was a part of the RFP and the continuation application, although they did not punish for not obtaining reimbursement.

K. Coleman asked if there were specific issues that clients had seen in case management. E. Torres replied that they had received very positive results overall, and that she was only surprised that so many clients had said they had been in case management for over seven years. K. Coleman then asked how they were going to collect information from providers. E. Torres replied that program analysts would visit the providers to collect information. She went on to say that they had also had a suggestion to have a focus group in about three months to see how things were going.

E. Torres went on to discuss the information and referral data, noting that their number of calls was going down. She then stated that she thought this could be a result of the growing popularity of text messages and the internet. A. Ricksecker stated that their group had begun to discuss nPEP, which required a medical provider to do a biomedical method of prevention. She asked how the I/R line could help as they began to let providers know how to about this service. E. Torres replied that they did have a protocol for nPEP, which involved sending a client to a Health Center. She noted that they had been working with Dr. Kwakwa on this, and that they had established a specific contact at each Health Center. A. Ricksecker asked if the counselors do a risk assessment. E. Torres replied that they do not, but they do ask about the window. K.

Coleman asked if this information was communicated to providers. A. Ricksecker stated that the ETC had been asked to determine how this situation was handled, and to survey the providers. She noted that Dr. Kwakwa was on the committee.

E. Torres moved on to review demographic information for I/R calls, noting that most of the clients calling were ages 23-40. She then turned the presentation over to M.B. Shannon.

M.B. Shannon began by reviewing the Housing Services Program, noting that there is a positive correlation between stable housing and positive health outcomes. He pointed out that they are the centralized intake only for permanent housing, and that "homeless" is defined by the federal McKinney Act. He noted that they had had a recent increase of forty housing slots due to additional funding from HUD, adding that they would try to fill all of those slots by the end of January. C. Ambrose asked how many project-based housing units there were. M.B. Shannon replied that project-based units represented less than 70 housing slots. C. Ambrose asked how many buildings these units were in. M.B. Shannon replied that some slots were in a building with multiple units, while other times slots were houses.

K. Coleman asked how information is communicated to case managers about housing. M.B. Shannon replied that AACO conducts training on housing every four months, and that he sends out a general announcement as well as a special invitation for those that need to attend. A. Ricksecker stated that there is a constant struggle between Ryan White's role in housing and the AACO housing program. She then asked how much funding the AACO housing program receives. M.B. Shannon replied that this program receives approximately $9 million. He then stated that there were approximately 200 people on their waiting list, and only four were homeless. He noted that the waiting time was up to nearly two years, with although the waiting list for the homeless was less than six months. He added that this list did not include the forty brand-new slots. He then noted that filling those forty slots should reduce the wait list to about eighteen months, although the wait would become longer as time went on.

M.B. Shannon went on to review the medical criteria for AACO housing. E. Torres stated that they did have the option to open this program to those with HIV, but that they had a limited number of slots and this could increase the waiting list to three or four years. M.B. Shannon then reviewed the requirements in terms of income. C. Ambrose stated that the level for low income was very high. M.B. Shannon noted that fair-market rent is about $700 for a one-bedroom in Philadelphia, and that a consumer was responsible for paying 30% of their income toward rent, so once a consumer earns about $30,000 there is no benefit to participating in the program. He then reviewed the other criteria, noting that homeowners were disqualified. He went on to discuss the funding for the program.

A. Ricksecker stated that they did not know how many people with HIV were living under other OHCD-sponsored housing programs. C. Ambrose asked AACO's Housing Program was run through the same program as Section 8. M.B. Shannon replied that it was not, and that there was an eight-year wait for Section 8. E. Torres noted that it would be interesting to see how many PLWHA are receiving housing through other programs. M.B. Shannon noted that they encourage clients to apply for as many programs as they are eligible for. He then reviewed the various housing objectives addressed by Ryan White, and which service categories they are addressed under. He explained that Ryan White provides support around housing, even if it does not provide housing itself. A. Ricksecker stated that most of the PLWHA on the waiting list were not homeless, and they could get referred to another provider. M.B. Shannon stated that a consumer could go to a housing counselor, get transitional housing for 24 months, and also get on the waiting list for AACO housing. He then explained that most people in this program stay in the home they have been living in for years. E. Torres noted that Shelter Plus Care had to be matched to supportive services. She added that OHCD also pays for housing counselors. M.B. Shannon then reviewed statistics from the Housing Services Program, noting that 24.6% of clients had drug/alcohol history within the past year. He noted that the typical applicant is an African-American male in his mid-40s receiving income from the Social Security Administration.

E. Torres stated that AACO also funds Calcutta House, McAulay House, Bucks Villa, and Good Shepherd. She went on to say that they had had 30 complaints filed in 2008, and that agencies were required to have their own internal grievance process. She then reviewed information about the case management coordination project. A. Ricksecker asked what geographical area is covered by medical case management intake. E. Torres replied that it covers Philadelphia and the PA Counties, and that they would start to include some New Jersey data beginning January 1. She went on to say that New Jersey has its own HIV testing hotline. She noted that they give information on all providers that are funded. A. Ricksecker asked if the Housing Services Unit served only Philadelphia. M.B. Shannon replied that HSU had recently expanded to all of Southeastern PA. M. Myers asked if someone receiving rental assistance could access DEFA for rent or utilities. M.B. Shannon replied that a person in this situation could not access DEFA for rent or utilities. A. Agha asked if a consumer had to remain active in case management once they obtain housing. M.B. Shannon agreed. E. Torres noted that they had had tried to change the policy to allow a consumer that had been verified as stable with a case manager to be released from this requirement, but that it had not been accepted.

Old Business:

- **Recapping the Priority Setting Conversation**

A. Ricksecker stated that they had discussed a great deal in their previous meeting, and asked those present to go through the minutes to tease out the important points. K. Coleman pointed out that New York only conducts a complete prioritization process every three years. A. Ricksecker stated that the 100-point scale for weights on the factors was different from their own 5-point scale.

C. Ambrose stated that she was disappointed that members of other committees did not attend the current meeting. K. Coleman replied that they had invited everyone several times.

M. Ross-Russell noted that particular differences in the New York process included: a designated committee for Priority Setting/Resource Allocation; a scale that had been adjusted in 2008 based on their lessons from the 2005-2007 process; a change of the weights to add to 100%; off-years where they would make minor tweaks; validity checks that went to the Executive Committee (made up of chairs from all committees); covering three to four categories per committee meeting; completion of score sheets prior to meetings; allowing only those at the committee meetings to score and vote; time limits on discussion; consensus on scores for service categories; and finally, rationale behind the consensus was captured to be used as support. She went on to say that the consensus also helped them to cover all questions before designating a score. A. Agha added that they also had no more than 5 of any score using the 0-8 scale.

C. Ambrose pointed out that New York prioritized fewer service categories. M. Ross-Russell clarified that they only prioritize the funded service categories, and their score cards were based on data that could only be obtained for funded services. A. Ricksecker clarified that they did discuss what to do in the case of a new service category. M. Getahun noted that New York had also discussed the tool with RWPC members three times throughout the year before using the process. She then stated that their own committee had previously discussed beginning to use their tool several months earlier, although the town hall data would not be the most recent. C. Ambrose replied that they did not need to use the current year's data for the tool. A. Agha agreed that town hall data did not change significantly from year to year. M. Ross-Russell noted that NYC also has a very good Medicaid system, as well as public hospitals, so they approached ambulatory care differently. She then explained that ADAP Plus was a combination of ADAP and ambulatory medical care.

A. Ricksecker noted that New York City keeps Priority Setting and Allocations separate, and their list of priorities only kicks in when there are significant cuts. M. Ross-Russell noted that they also did their cuts based on percentages. A. Agha pointed out that they also use one less factor in NYC, since they rolled service utilization into other service categories such as specific gaps/emerging needs. A. Ricksecker asked how utilization would be considered in that factor. C. Ambrose suggested that they could look at an increase in utilization as an emerging need. M. Getahun noted that the NYC Needs Assessment Committee had also determined specific populations in need that were listed on the score cards. M. Ross-Russell cited youth outreach as a category that they had specifically developed. She noted that New York had the capability to shift money to specifically target a population, although the group had to come to consensus. She explained that Philadelphia had this capability, and that they had earmarked money for specific populations in the past through the instructions to the grantee. She went on to say that they would also want to consider that NYC receives much more funding than Philadelphia, and that New York state had tracked their HIV data from the very beginning. C. Ambrose asked if they had ever considered getting a university involved in a project that would provide useful data. M. Ross-Russell replied that projects had been completed through the University of Pennsylvania, although these were usually done through the Health Department or the City. C. Ambrose stated that she would think an academic institution would be interested in this type of project without funding.

A. Ricksecker stated that they would need to think about what possible changes they would report to the RWPC. K. Coleman stated that they had a long list, and that they would need to have a more in-depth conversation about what they would like to take on. C. Ambrose suggested having another open meeting where they would present some of the differences to other committee members. A. Ricksecker stated that she wanted more RWPC members to score the service categories this year. J. Churchville stated that they should begin the discussion of changing their process in 2011, and that they needed more time to see how the same process would look in 2010. C. Ambrose agreed that the committee needed more time to make changes. She went on to say that it would be helpful to have a consultant come in to explain this to everyone. K. Coleman stated that she agreed with J. Churchville about not making major changes for another year, but that they might look at making minor changes, like validity checks. J. Churchville clarified that he considered tweaking to be a natural result, and that when he was talking about making changes, he meant major changes to weights or categories.

A. Ricksecker stated that the weights on the factors were the pivotal point with the other RWPC members. C. Ambrose stated that she thought switching to a score total of 100% would help with concerns about the weights. M. Ross-Russell agreed that this would help to make their math cleaner when explaining the process to others. A. Agha noted that A. Santella had said that easier math had helped them to gain more buy-in from community members. A. Ricksecker stated that they would not be changing factors for now.

A. Ricksecker asked the group what they would like to report to the RWPC at their next meeting. She noted that they would report some of the differences between Philadelphia's and New York's processes. K. Coleman stated that they should also inform the RWPC that they were discussing what, if any, changes they might make to the process.

M. Ross-Russell stated that the committees had had joint meetings and data meetings leading up to Priority Setting in the past. She asked the group if they wanted to return to holding joint meetings between the Finance, Needs Assessment, and Comprehensive Planning Committees. She then asked the group if they wanted to use the score card format to review data, even though it contained much of the information that they already review. A. Ricksecker agreed, and asked M. Ross-Russell to show the scorecard to the Finance Committee. C. Ambrose stated that she wanted all committees to be involved in the Priority Setting process, and that some committees may have to put agenda items on a parking lot this year. She went on to say that they would need more people to be involved to make priority setting a seamless process.

M. Ross-Russell reminded the group that they had moved away from having additional joint meetings three years ago because they had created a very busy schedule. She went on to say that the data meeting had tended to be overwhelming. A. Ricksecker replied that the score card would be critical for the data meeting. M. Ross-Russell noted that they typically held the data meeting early in the year, so they would use the previous year's data.

K. Coleman stated that they had previously agreed to set aside time on their agenda to discuss the Goals and Objectives in each meeting. She then asked if their group would be able to complete all of their work in a two-hour monthly meeting. A. Ricksecker replied that they would need to think about the time required to score each service category. C Ambrose suggested considering only scoring the funded service categories.

A. Ricksecker suggested including a sample score card with the RWPC handouts.

C. Ambrose asked if they needed to present joint meetings as a motion before the RWPC. M. Ross-Russell replied that a motion would not be necessary. C. Ambrose suggested proposing this to all of the committees.

A. Ricksecker stated that they were going to make some basic statements on what they had already agreed on in their report at the RWPC meeting. M. Myers added that this could also be an opportunity to get feedback from other RWPC members.

New Business:
None.

Announcements:
None.

Adjournment:
The meeting was adjourned at 12:12 p.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from November 16, 2009
- Philadelphia Department of Public Health CSU Slides
- OHP Calendar