

**Ryan White Planning Council (RWPC) of the Philadelphia Part A EMA
Joint Meeting of the Comprehensive Planning and Needs Assessment Committees**

Meeting Minutes of

Wednesday, December 1, 2010

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 (Co-Chair), Karen Coleman, Dawna Edwards-Watson, Gerry Keys, Michael Myers, Ann Ricksecker (Co-Chair)

Excused: Peter Houle, Sandra Thompson

Absent: Marcelo Fernandez-Viña, Raymond Hayward, Eric Paulukonis, Ronald Sy

Guests: Jamie Hamilton (AACO), Evelyn Torres (AACO)

Staff: Debbie Law, Michael Milsop, Briana Morgan, Nishika Vidanage

Call to Order/Introductions:

J. Churchville called the meeting to order at 10:11 a.m. Those present then introduced themselves.

Approval of Agenda:

J. Churchville presented the agenda for approval. A. Ricksecker stated that the election of a new co-chair ought to be added as an agenda item. **Motion: A. Ricksecker moved, K. Coleman seconded to approve the agenda as amended. Motion passed: All in favor.**

Approval of Minutes:

J. Churchville next presented the November 10, 2010 minutes for approval. K. Coleman stated that she had not been present at that meeting, and should have been marked as excused. C. Ambrose stated that Kathleen Brady should have been included as a guest at that meeting as well. **Motion: M. Myers moved, C. Ambrose seconded to approve the November 10 minutes as amended. Motion passed: All in favor.**

Report of Staff:

M. Milsop stated that Part B Priority Setting would be taking place at Action AIDS on Friday, December 3 from 10:30 a.m. – 3:30 p.m. B. Morgan then stated that the Finance Committee meeting originally scheduled for the next day had been cancelled.

Report of Co-Chair:

A. Ricksecker stated that the co-chairs of the committees would be meeting on Thursday, November 9th to discuss the results of the RWPC membership survey. J. Churchville encouraged A. Ricksecker to attend this meeting, even though her term as co-chair of the Comprehensive Planning Committee was ending.

J. Churchville then stated that the Black Treatment Advocates Network had begun planning activities for 2011. He added that they would be conducting trainings in order to keep the community up-to-date and informed.

Action Item:

- **Co-Chair Elections**

J. Churchville stated that they would be holding an election for the co-chair of the Comprehensive Planning Committee. He noted that M. Myers was their sole candidate, and opened the floor for voting. **Motion passed: 4 in favor, 0 opposed, 0 abstentions.** M. Myers stated that he would do his best to follow in the footsteps of their former co-chairs, and went on to say that he and J. Churchville would work together as the new co-chairs. He next stated that he planned to ask the former co-chairs for advice on leading the committee. He added that he had been very happy with the committee's progress and work over the five years he had been a member of the RWPC.

Discussion Items:

- **AACO's Client Services Unit and Housing Unit**

E. Torres began her presentation by discussing medical case management (*see – attached slides*). She stated that they reviewed two major performance measures, including retention in medical case management eight weeks after intake, as well as retention in HIV medical care for those that were retained in medical case management. She then discussed additional performance measures as prescribed by HRSA, noting that the medical case management model had been in place in Philadelphia for just over a year. She explained that they also reviewed data on oral health visits, two CD4 counts at least three months apart, two viral loads at least three months apart, cervical cancer screening, and documentation of HIV medications. K. Coleman asked what data is collected in regards to oral health care. E. Torres replied that case managers are asked to document a client's number of oral health care appointments. J. Churchville asked what "HAB" stood for. E. Torres replied that "HAB" is the HIV/AIDS Bureau, which is the part of HRSA that administers Ryan White. C. Ambrose asked if the data collected reflected completed dental appointments. E. Torres agreed that the referral should be completed. G. Keys then asked if mammographies are used as a performance measure. E. Torres replied that they are not, explaining that they had chosen cervical screenings as a performance measure because they had very low numbers in this area, and they were directly related to HIV.

A. Ricksecker stated that some RWPC members had replied that they do not receive information on quality management in the membership survey. She explained that the Comprehensive Planning Committee receives an annual presentation on quality management, and it would be important to convey this information to the RWPC.

M. Milsop stated that some jurisdictions had begun providing dental case management, and asked E. Torres if this could be helpful in their EMA. E. Torres replied that this was not currently available in the Philadelphia EMA, and she was not sure if they would have the resources for that service.

E. Torres then moved on to review the Client Services Unit (CSU). She explained that AACO receives intake data from New Jersey, although New Jersey is not a part of AACO's system. She moved on to review the CSU's mission. She noted that they had originally had weekend hours for the hotline, but they had ended these as a cost-saving measure due to very, very low utilization. D. Law asked for more information on New Jersey's intakes. E. Torres replied that New Jersey does its own intakes, but sends AACO information on these intakes so they are able to track them. D. Law then asked if there had been new trends in

New Jersey referrals. E. Torres replied that there had been an uptick in calls in New Jersey due to the closure of a provider, adding that the transition had gone very smoothly.

E. Torres next discussed case management intakes, including demographic information. She noted that the demographics for those coming into case management were in keeping with the epidemic. K. Coleman then asked if the CSU had seen an impact from the policy of closing a case once a client seems to be medically stable. E. Torres replied that this was an interesting question, explaining that most clients are hesitant to give up a case manager even when they are doing well. K. Coleman explained that it could become problematic if they were repeatedly closing and reopening the same cases.

E. Torres then stated that 87% of clients were below the federal poverty level at intake. She then reviewed insurance status for CSU intakes before discussing the client needs at intake. K. Coleman asked if the benefits category would include health insurance. E. Torres replied that health insurance was tracked separately. She then stated that there were 143 clients on the CSU waiting list, explaining that social workers contacted those on the waiting list monthly in order to address any emergency situations. She went on to say that providers tended to take emergency clients very quickly, noting that this category would include homeless clients, as well as those being released from state correctional institutions. A. Ricksecker added that clients could now apply for Medicaid before release from prison. E. Torres replied that this was a great program, adding that these clients would also be released with thirty days of medications.

C. Ambrose asked how long a client could expect to be on the CSU waiting list. E. Torres replied that some clients on the list were waiting to go to a specific agency, but the typical wait would be four to six weeks.

E. Torres then reviewed the number of calls received on the hotline, noting that this number had decreased steadily. She also reviewed data on the HIV texting campaign. A. Ricksecker then asked how AACO staff kept their information up to date. E. Torres replied that they have an internal information and referral specialist that gathers data every six months. A. Ricksecker then asked if the CSU hotline would only refer clients to providers that are funded by AACO. E. Torres agreed that this was generally true, but they did include shelter systems. She then reviewed data for information and referral calls, including the most frequently referred services in 2010 and demographic information.

Next, J. Hamilton began to review information on the Housing Services Program (HSP), including the role of the HSP. She noted that they currently had eight housing sponsors, rather than seven as listed on the slides. M. Myers asked if they would adjust the number of bedrooms for an apartment if the client's family composition changes. J. Hamilton replied there was a transfer program available for this situation, explaining that they used HOPWA standards for the number of bedrooms. She then stated that there were currently 163 applicants on the waiting list, including one homeless person. She went on to say that they had expanded the medical criteria over the past month, so clients were now able to apply if they have an AIDS diagnosis, meet criteria for SSD, or have had a documented case of oral hairy leukoplakia, herpes zoster, or oro-pharyngeal candidiasis within the past six months. She also reviewed the HSP criteria and disqualifications as well as the demographics of applicants.

A. Ricksecker then stated that she was struck by the fact that 37.4% of applicants were currently in mental health treatment, and asked if there was a way to provide wraparound services in the living arrangement. J. Hamilton replied that wraparound services were not a part of their program, so the case manager would need to address any of these needs. She went on to say that HSP did ensure that any applicants with a mental health diagnosis were actively engaged in mental health care. E. Torres added that they also ensured that applicants could live independently. M. Milsop noted that there was specific funding available through COHMAR for PLWA with mental health issues.

A. Ricksecker then stated that she had received an email regarding open housing slots in Wilmington, and asked what she should do with this information. E. Torres replied that Delaware was outside of AACO's service delivery area, so clients could move to Wilmington but they would lose their current services. She went on to say that they were looking at ways to distribute more information on non-HIV-specific housing to their case managers. She explained that ACT UP had asked the mayor to support federal funding for housing with additional city funds, although it did not seem as though there was additional funding available. She then stated that there were other sources for housing, noting that the Philadelphia Housing Authority (PHA) had a total of 30,000 housing slots. She went on to say that ACT UP was also pushing for a housing-first model, adding that this model required a great deal of supportive services. She noted that ACT UP wanted to open the housing waiting list to all people living with HIV that were currently on antiretrovirals. She explained that AACO had done an estimate on this, and that this policy could possibly place 14,000 PLWHA on their waiting list, while they only had 663 housing slots. She added that not all of those 14,000 people would definitely need homes, but that this would be the potential pool of applicants. A. Ricksecker then stated that she was curious about intake policies for those with chronic illnesses in non-HIV specific housing.

J. Hamilton then stated that AACO had been making changes to the housing program, including the previously mentioned expansion of the medical requirements. She noted that they had also developed a new application. She went on to say that AACO-funded medical case managers were now able to certify that their clients were homeless, so they no longer required shelter documentation.

E. Torres then began to review the feedback process. She stated that there did not seem to be a trend in complaints regarding medical case management. She went on to say that complaints included rude case managers, problems with the submission of housing and DEFA applications, and DEFA appeals. She then stated that they had heard complaints that some landlords had taken DEFA money from clients and then refused to rent to those clients, so AACO had begun a blacklist for those landlords. She then stated that most dental complaints were due to scheduling issues. M. Milsop noted that there had been a lot of complaints regarding dental services in the town halls. E. Torres then added that agencies were required to have an internal grievance process.

Lastly, E. Torres reviewed the Case Management Coordination Project. She stated that they were unable to track any issues with co-pays, although she had had a client call her because his deductible was being raised to \$4,000. She went on to say that she had not received any calls related to medical transportation services, explaining that any transportation-related calls were regarding LogistiCare rather than AACO-funded transportation. She then stated that they also had data available on intakes as a result of the closure of a New Jersey

provider. C. Ambrose stated that it would be helpful to review gaps in insurance by age, gender, and race. E. Torres agreed to gather this information, as well as data on risk category. C. Ambrose then asked for risk category data by gender.

A. Ricksecker then asked for information about the follow-up process for feedback. E. Torres explained that the process would begin with a client calling to lodge a concern. She noted that the client's concern would need to be related to current services, and that they also as the client to provide an ideal resolution. She went on to say that they proceed to explain whether this resolution would be possible, and then pass this information on to the director of the agency. She explained that the director would then have a conversation regarding a potential solution with the program analyst, and this would then be forwarded to the program supervisor before she would review it herself. She noted that the client, program analyst, and provider would then be notified of the resolution. She then explained that a potential solution could include staff training and written policies.

M. Myers and J. Churchville then thanked E. Torres and J. Hamilton for their presentation. M. Myers next asked if AACO's HSU would only accept the three previously mentioned opportunistic infections for the housing application. J. Hamilton explained that the Social Security Administration (SSA) did not consider these three to be AIDS-defining, so these were in addition to the SSA's guidelines.

Old Business:

None.

New Business:

A. Ricksecker stated that it was very helpful to have a joint meeting between the Needs Assessment and Comprehensive Planning Committees for these types of presentations, since members of each committee would hear the information differently. She went on to say that they had had very stable membership in the Comprehensive Planning Committee, and that she was glad to see M. Myers as the new co-chair.

A. Ricksecker then stated that there had been two items mentioned in the current meeting that would be important to bring before the co-chair meeting: bringing quality management data to the full RWPC, as well as determining what role the RWPC could play in advocating when a voice was needed. E. Torres replied that advocacy would be very important due to the new administration coming into the state government. She explained that the state was planning to make a large cut to its budget. C. Ambrose then asked if the RWPC would be able to advocate in this situation. A. Ricksecker replied that this would be an important topic for the co-chair meeting. J. Churchville stated that they RWPC would be able to make a statement based on any information they gathered. He went on to say that they had a responsibility to do good for the people they represent, though they would need to find a legal way to make any statements. He added that they would be able to make statements as long as they were clear on what they were allowed to do, and they were not lobbying.

C. Ambrose then suggested asking Office staff to review what the RWPC would and would not be able to do. A. Ricksecker replied that they should not do this, as the co-chairs meeting ought to be a brainstorming session. She went on to say that they had previously heard a suggestion on forming a policy committee from Alan Edelstein. M. Myers then stated that the group had previously discussed the importance of supporting the Positive Committee. He

explained that it would be important to help give consumers a voice as well as establish a plan to help the consumers advocate for themselves.

Announcements:

D. Edwards-Watson stated that she would be interviewed on Channel 29 as a part of World AIDS Day. J. Churchville then stated that he, D. Edwards, and another colleague had reached 400 community members in Germantown through a survey tool, and they were currently analyzing the data. He explained that they were trying to determine how informed the community members were about HIV/AIDS, and that they planned to return to give those community members additional information based on what they already knew or did not know.

Adjournment:

The meeting was adjourned at 11:25 a.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from November 10, 2010
- Philadelphia Department of Public Health Slides
- List of Questions for the CSU
- OHP Calendar

RYAN WHITE PART A PLANNING COUNCIL (RWPC)
Comprehensive Planning Committee
Meeting Agenda
Wednesday, December 1, 2010 10am – 12pm
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

Call to Order/Introductions

Approval of Agenda

Approval of Minutes

Report of Staff

Report of Chair

Discussion Items

- **AACO'S Consumer Services Unit**
- **AACO's Housing Unit**

Old Business

New Business

Announcements

Adjournment

Meeting recap from last month:

- Reviewed Health Insurance Premiums & Cost Sharing Assistance
- Co-Chair Elections

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

The next meeting of the Comprehensive Planning Committee is Wednesday, January 5th, 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 EMA
Comprehensive Planning Committee Meeting**

Meeting Minutes of
Wednesday, November 10, 2010
10:00 a.m. – 12:00 p.m.

Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia, PA 19107

Present: Christine Ambrose, Karen Coleman, Ann Ricksecker (Co-Chair), Sandra Thompson

Excused: John Churchville (Co-Chair), Peter Houle, Michael Myers

Absent: Alicia Beatty, Marcelo Fernandez-Viña

Guests: Ralph Charter

Staff: Michael Milsop, Briana Morgan, Nishika Vidanage

Call to Order/Introductions:

A. Ricksecker called the meeting to order at 10:18 a.m. Those present then introduced themselves.

Approval of Agenda:

A. Ricksecker presented the agenda for approval. The agenda was approved by general consensus.

Approval of Minutes:

A. Ricksecker next presented the October 6, 2010 minutes for approval, and reviewed points from the previous meeting for the benefit of those present. **Motion:** C. Ambrose moved, S. Thompson seconded to approve the October 6 minutes. **Motion passed: All in favor.**

Report of Staff:

M. Milsop stated that Part B Priority Setting would be taking place at Action AIDS on Friday, December 3. A. Ricksecker suggested asking a representative from the Comprehensive Planning Committee to attend that meeting. She then asked who facilitates Part B Priority Setting. M. Milsop replied that the Office facilitates the process, and that they typically break out into separate discussions for Philadelphia and the other PA Counties.

Report of Co-Chair:

None.

Discussion Items:

- Health Insurance Premium/Cost-Sharing Assistance

A. Ricksecker stated that the Planning Council had included a placeholder for health insurance premium/cost-sharing assistance during the allocations process, and that the committee would be investigating this category. M. Milsop directed those present to review information about four other EMAs' programs (*see – attached handout*), noting that Dallas was missing from the list of other jurisdictions funding this category. He explained that each EMA was different; for example, some had income requirements while others did not. He went on to say that he had included the allocations for this category in each EMA as compared with their total grant amount. K. Brady noted that the first three items covered by Houston's program were already covered by SPBP in the state of Pennsylvania. She then stated that SPBP would not cover lab co-pays or co-pays for doctors' visits for those with private insurance. M. Milsop next explained that Miami subcontracts this service category in a way similar to the way that DEFA is subcontracted in Philadelphia, while in Houston the providers or consumers submit bills directly to the health department. He went on to say that the income level for state ADAP in Houston was much lower, so they chose to cover more services. A. Ricksecker asked what SPBP covers. K. Brady replied that SPBP covers HIV medications, co-pays and deductibles for medications (including non-HIV medications) for those meeting the criteria, lab costs, and Medicare Part D premiums.

M. Milsop then stated that some EMAs pay for health insurance premiums if the policies were in danger of being cancelled, but they would not pay for cancelled policies or new policies. He went on to say that Miami, Hartford, Tampa and Jacksonville had caps on these payments for health insurance premiums. He noted that Baltimore's program only paid for medications. K. Brady expressed surprise that there were no income requirements for Miami's program, since the allocations were fairly low. M. Milsop then noted that some of the programs required the client to be engaged in medical care. A. Ricksecker replied that this would be a good way to encourage clients to get into care. M. Milsop noted that New Orleans pays for dental insurance premiums in addition to medical insurance premiums.

A. Ricksecker asked if it seemed as though all providers in these EMAs were required to accept payment through these programs. M. Milsop replied that providers were not required to accept this program, but they did tend to accept it. He went on to say that he had not heard any problems with this service category, and that it seemed as though those in participating EMAs liked it. He then stated that Bristol Meyers Squibb had held a meeting with regional planning bodies on Monday, in which they had done a talk on the costs associated with keeping someone in care as opposed to letting them lapse but return to care once sick.

A. Ricksecker next asked for more information about future developments with SPBP. M. Milsop explained that SPBP planned to look at the viability of funding this service category in the future since it might be more cost-effective, although they were unsure what the effects of healthcare reform would look like. A. Ricksecker replied that it would be important to consider any changes to SPBP as they reviewed this category, in order to determine how they could best compliment that program. K. Brady stated that the HealthChoices Workgroup would need to consider eligibility criteria as well as what

would be covered. She went on to say that there were many possibilities for funding in the future, but they had not made any decisions yet. She then explained that they would also have to balance their rebates with their other funding, particularly because HRSA required that they spend all of the rebate dollars first. She noted that possibilities for changes to the program included adherence programs or increasing income eligibility to 500%. She added that they had only had one meeting thus far, and they would need to make decisions about what medications to add to the formulary in the future.

A. Ricksecker stated that the committee would need to have a partnership discussion with Harrisburg. K. Brady agreed that they would not want to have two systems covering the same things. M. Milsop noted that New Jersey would not be covered by SPBP, and they were bordering on the start of waiting lists for ADAP. K. Brady stated that the health insurance premium/cost-sharing assistance could help them to make access to certain services equitable across the EMA. C. Ambrose stated that this could become a discussion for Priority Setting and Allocations. K. Brady stated that the HealthChoices Workgroup had also discussed creating contracts for the individual planning regions so they could use the funding as needed. She noted that this would help to spend down any underspending toward the end of the year.

C. Ambrose stated that it was a tremendously helpful that SPBP was helping to pay for labs. She went on to say that it would be helpful to have Cheryl Henne speak to providers about what is available through SPBP. M. Milsop replied that C. Henne had attended other meetings as invited, and would most likely be willing to come to Philadelphia for a meeting. A. Ricksecker added that they could conduct a webinar if traveling was an issue.

A. Ricksecker then stated that it seemed as though 17% of Ryan White clients were uninsured, based on data from the committee's previous meeting. K. Brady replied that 5.2% of PLWA were uninsured, while 7.4% of PLWH were uninsured. She went on to say that approximately 25% of PLWA had an unknown insurance status, and an even higher percentage of PLWH had an unknown insurance status. She also noted that about 11% of the newly diagnosed were uninsured. A. Ricksecker replied that they could use that information to determine how they would need to fund this service. K. Brady said that 16.9% of PLWHA in care in 2009 were uninsured, 39% of the uninsured did not have evidence of care in 2009, and 46.8% of those with unknown insurance status did not have evidence of care in 2009. A. Ricksecker replied that the RWPC had placed a high value on access to care, and this was compelling data. She went on to say that the data on unmet need spoke to a need for this service category. K. Brady stated that they had asked clients for information on whether their insurance status had changed, why it had changed, and what impact this had had on care as a part of the Medical Monitoring Project. She went on to say that 10% of people they interviewed had had a change, and the majority of changes were due to loss of employment, while some others had become eligible for Medicare/Medicaid. She noted that the Medical Monitoring Project interviews were conducted in Philadelphia but included PLWHA that receive care in Philadelphia from all counties.

A. Ricksecker then asked R. Charter what issues he had seen on this topic at Action AIDS. R. Charter replied that more clients were having problems with co-pays for specialists, under any insurance. He explained that there was a great deal of encouragement for gynecological screenings, but clients were unwilling or unable to cover the specialist co-pays. K. Brady stated that co-pays of \$50 were not uncommon, which could be a major disincentive. A. Ricksecker added that the least expensive policies would not cover these visits either. R. Charter stated that they had seen similar issues with mental health treatment, which prevented many people from engaging in this care due to co-pays., even with private insurance. He went on to say that, out of 1120 active clients at Action AIDS, 154 were uninsured, and 61 had mental health issues but were not accessing services. He then stated that many agencies had sliding scales for payment, but they still needed to have enough money coming in to stay in operation.

R. Charter next stated that his agency had also seen a lot of clients that were questioning why they were working. He explained that they were not sure how many people were actually dropping out of the work force, but they would be having different conversations with their clients if their co-pays and insurance premiums were covered. K. Brady replied that she had seen a lot of clients that were just over the income limit for SPBP, and these clients could see medication co-pays of \$300 per month. She went on to say that she had one client that had worked two jobs, but quit one of them so she could get SPBP. R. Charter stated that there were also many clients that were dual-eligible, and some of the providers were not clear on the policies and might deny co-pay coverage when they should not. He explained that this caused clients to become frustrated and stop attending appointments. K. Brady stated that she had also heard about a large number of mistakes regarding co-pays at pharmacies in particular. R. Charter stated that he was glad to hear that Part D premiums were covered under SPBP, but they had to ensure that any new systems were as simple as possible. He explained that people would be less likely to use more complicated processes. K. Brady agreed, noting that lab coverage under SPBP was a good example of this. She went on to say that there had been relatively low utilization of the lab portion of SPBP coverage, and that this could be due to providers not knowing how to access this. C. Ambrose agreed that this was a very complicated process.

M. Milsop stated that there had also been discussion around raising the disability requirements for SSI and SSD. A. Ricksecker replied that they should consider this alongside healthcare reform when reviewing this service category.

K. Brady stated that there was another program available for those that are disabled that allowed participants to make up to 500% of the poverty line. M. Milsop replied that this was Medical Assistance for Workers with Disabilities (MAWD). R. Charter explained that there is fairly minimal documentation required for this program. M. Milsop noted that there was a premium for this program, and R. Charter added that this was \$35 per month. A. Ricksecker stated that they should consider MAWD in their discussions on health insurance premium/cost-sharing assistance. M. Milsop agreed, adding that this was an underutilized program.

M. Milsop then stated that the majority of the health insurance premium/cost-sharing assistance programs in other EMAs had been designed to keep people that already had a policy in care. C. Ambrose stated that MAWD was only \$420 per year, but would keep people in medical care. R. Charter noted that this program was helpful for those that recently lost their jobs or were waiting for SSI to begin.

A. Ricksecker asked if other EMAs covered COBRA payments, and M. Milsop agreed. K. Brady and C. Ambrose noted that Miami's allocations would cover 227 clients per year if they paid the maximum amount for each client. A. Ricksecker stated that it sounded as though this was a pursuable service category based on local information, state information, and information from other EMAs. She went on to say that they would need to think about the committee's role in the development of this category after the current meeting. C. Ambrose replied that they could get more specific information on SPBP, as well as request more information around health care reform. A. Ricksecker replied that they could ask for more information, but as they could shift funding out of a category if it was underspent, it could be unnecessary to wait for more information. M. Milsop stated that the group could state that they would like to see a program that had certain components, and allow the health department to look into such a program. K. Brady noted that they could also include qualifiers in case other programs changed.

M. Milsop stated that the committee could make a suggestion to the grantee regarding this service category. A. Ricksecker replied that they would be looking at changes eighteen months in the future, since they would not be able to change anything for the next year. B. Morgan clarified that it was technically possible to alter the allocations plans from the original plans once the awards came in, if there was a documented need for the service. A. Ricksecker stated that it would be important to address this issue with the Finance Committee. C. Ambrose stated that there was no question that there was a need, and they would need to see what would actually be possible with the grantee.

A. Ricksecker then stated that she would speak to A. Edelstein about this category. M. Milsop stated that other RWPC members might ask them what the program would be like and what it would cover. C. Ambrose replied that this could cover COBRA payments, specialist co-pays, and clients not eligible for SPBP. A. Ricksecker then asked why dental care, gynecological care, and mental health services might receive special attention. R. Charter replied that these services frequently had higher co-pays, and medical providers were pushing access to these more than before due to an increased importance in standards of care. K. Brady noted that many people do not have dental insurance in particular. A. Ricksecker asked if they would be considering covering dental services. M. Milsop replied that going to dental clinics could be difficult for working PLWHA. He went on to say that AACO could possibly state what they could pay for under this program, and then find an organization willing to provide those services. K. Brady noted that they could also use a program like this for procedures not otherwise covered by Ryan White dental providers. M. Milsop

suggested including the possibility of covering vision care as well. A. Ricksecker asked if other EMAs covered vision care. M. Milsop replied that New Orleans specifically stated that they covered vision, and he believed that other EMAs also covered this, although it was not specifically mentioned.

• **RWPC Membership Survey**

B. Morgan explained that all of the committees had been asked to review the results of the survey, as well as consider how to improve the process and be more inclusive (*see – attached handout*). She stated that the co-chairs for the committees would meet in December to develop an action plan. C. Ambrose stated that she had been through this process with the Needs Assessment and Finance Committees, and that they had heard requests for buddies. She asked if this had been done before. B. Morgan explained that they had done this for the full RWPC in the past, based on volunteer availability from Nominations Committee members, but they had not done this on the committee level.

C. Ambrose suggested that the group look at the answers for Question #18. She stated that they should consider how they make decisions and distribute materials. She went on to say that the co-chairs should be able to review the agendas the day before. She next stated that there had been a suggestion to have 15 minutes at the end of each meeting to summarize what had happened, or 10 minutes at the beginning of the next meeting to highlight what happened at the previous meeting. She went on to say that the comment on pre-determined plans was alarming because they wanted to be transparent, but people seemed to think there an agenda had already been established. She also noted that a respondent had said that they were not talking about the quality of care in their meetings. She added that they had also discussed the Positive Committee newsletter. B. Morgan noted that the Positive Committee had agreed to including paragraphs about the other committees in the newsletter, and that the group would need to determine whether the committees or Office staff would write these.

A. Ricksecker stated that understanding data could be a struggle, and she did not think that the solution would be to send more data out. C. Ambrose stated that they needed to explain what was important and put it in context. She then suggested providing training on what each committee does. A. Ricksecker next stated that data is usually provided in its purest form, but it would be important to have someone pull examples out to explain what the data means. She went on to say that there was some interpretation needed that should not be the responsibility of the presenter. B. Morgan explained that they would need to be careful to explain the data without over-interpreting it, because the latter could contribute to the idea that the committees came into meetings with set plans.

M. Milsop stated that they had also seen responses from those in the PA and New Jersey Counties that had had difficulty getting to meetings in Philadelphia. A. Ricksecker replied that Drexel had a program for remote participation in meetings, in which they could use cameras to allow groups to meet and participate in meetings off-site. C. Ambrose then pointed out a comment on p. 3 from a member that did not understand the role of the committees or the role of staff on the committees. She stated

that it would be helpful to have a list of which member of staff supported each committee.

Old Business:

None.

New Business:

Motion: S. Thompson moved, C. Ambrose seconded to open nominations for the committee co-chair position. **Motion passed:** All in favor.

M. Milsop stated that K. Brady had confirmed that she would be able to participate in the committee's January meeting. C. Ambrose stated that the Needs Assessment Committee wanted to join Comprehensive Planning Committee for their December meeting. She then noted that the Comprehensive Planning Committee's December meeting was scheduled for World AIDS Day. A. Ricksecker replied that they should send a reminder to both the Needs Assessment and Comprehensive Planning Committees immediately so the members could add the meeting to their calendars.

Announcements:

None.

Adjournment:

The meeting was adjourned at 12:05 p.m. by general consensus.

Respectfully Submitted by,

Briana L. Morgan, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from October 6, 2010
- Examples of Health Insurance Premium & Cost-Sharing Assistance Programs
- RWPC Satisfaction Survey
- OHP Calendar

Philadelphia Department of
Public Health

AIDS Activities Coordinating
Office, Client Services Unit
December 1, 2010

Medical Case Management
MCM

MCM Emphasis

- The coordination and follow-up of HIV medical treatment
- Medical case management includes the provision of treatment adherence counseling



Medical Case Management Performance Measures

Performance measures	2008	2009	2010	Target 2011
Retention of MCM clients weeks/region	76%	80%	80%	85%
Retention of HIV medical visits/clients	87%	92%	93%	95%

MCM Performance Measures II

- Percent of HIV-infected MCM clients who had a MCM care plan developed and/or updated two or more times which are at least three months apart in the measurement year
- Percent of HIV-infected MCM clients who had a medical visit with a provider with prescribing privileges two or more times at least three months apart in the measurement year

Grantee MCM Performance Measures III

- Percent of HIV-infected MCM clients who had the following in the measurement year:
 - Oral health visit (HAB)
 - Two CD4s at least three months apart (HAB)
 - Two viral loads at least three months apart
 - Cervical cancer screening (HAB)
 - HIV medications documented

Client Services Unit

- 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

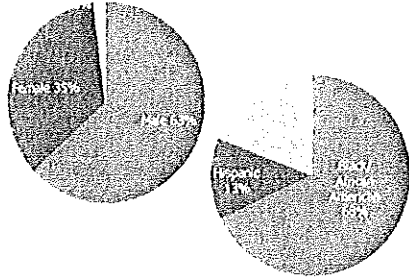
Intake Data

CM Intakes

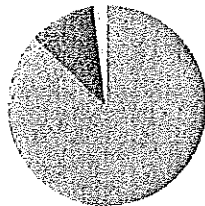
Calendar year	Unduplicated Intakes
2007	1720
2008	1803
2009	2,165

Of the 2,165 intakes performed in 2009, 1,086 (50%) did not have a previous intake.

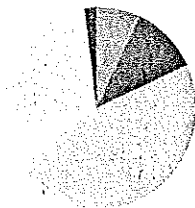
Calendar Year 2009
Demographics
N=2,165 clients



Calendar Year 2009
Federal Poverty Level (FPL)
N=2,165 Clients



Calendar Year 2009
Insurance
N=2,165 clients

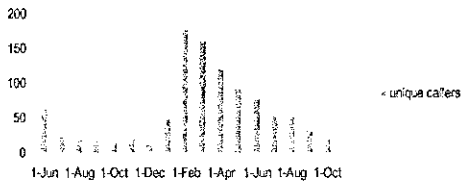


Information & Referral (I/R) Calls

Number of calls has decreased steadily since 2007 (possibly due to the decrease in advertising campaigns)

- 976 calls 1/1/07 – 12/31/07
- 630 calls 1/1/08 – 12/31/08
- 371 calls 1/1/09 – 12/31/09
- 230 calls 1/1/10 – 11/15/10

HIV Texting Campaign June 1, 2009 – October 30, 2010 N=1033

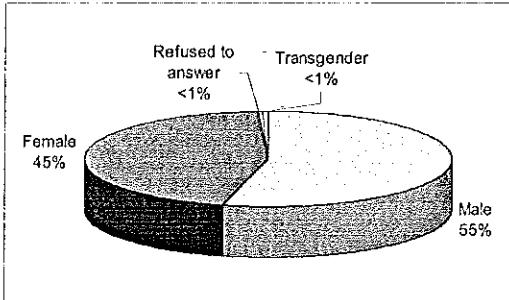


46% of callers received referrals for HIV testing

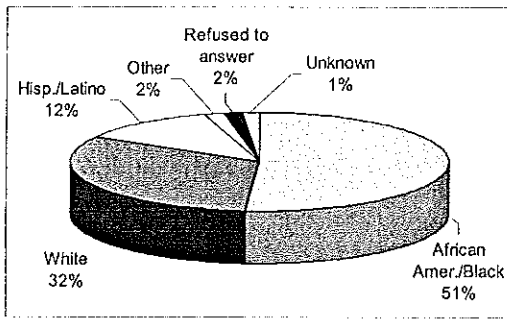
Rapid HIV Testing is most requested service (16% of total calls)

Most referred services for 2010	% of calls referred to service
HIV Testing	46%
Information only (no referrals)	20%
Other hotlines	14%
STD testing/info	7%
Medical care	3%

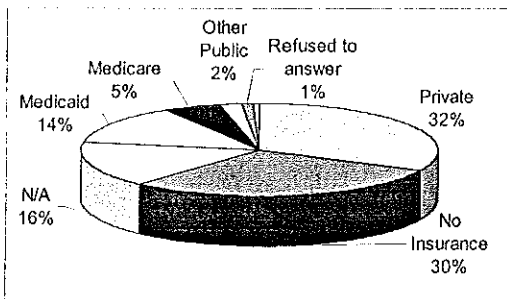
Gender- I/R Calls 2010



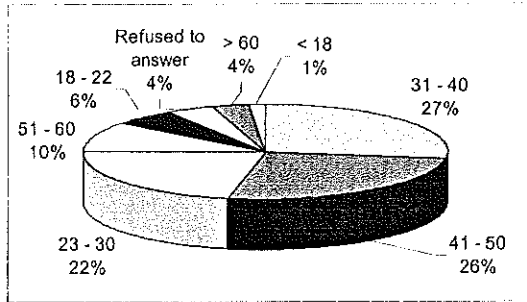
Race- I/R Calls 2010



Health Insurance Status- I/R Calls 2010



Age- I/R Calls 2010



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
- 663 housing slots
 - Recent increase of 10 slots
 - 522 HOPWA
 - 131 S+C
- 89% tenant based
- 11% project based

Waiting List

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

HSP Criteria

- Medical criteria
 - Must have AIDS diagnosis, meet criteria for SSD specifically due to HIV, or have documented case of oral hairy leukoplakia, herpes zoster, or oropharyngeal candidiasis within last 6 months.
- 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

HSP Breakdown

- Stats provided are for FY 09
- July 1, 2009 through June 30, 2010
- Total applications received – 280
 - Up 19% over FY 09
- Total referrals made for permanent placement – 112
 - Up 25% over FY 09

HSP by Gender

- | | | |
|---------------|-----|-------|
| ■ Female | 84 | 30.8% |
| ■ Male | 181 | 66.3% |
| ■ Transgender | 8 | 3% |

HSP by Race & Ethnicity

■ Black / AA	121	81.0%
■ White	17	6.2%
■ Latino	20	7.3%
■ Multiracial	14	5.1%
■ Native American	1	0.4%
■ Unidentified	3	1.3%
■ Zero identified as: Asian, Native Hawaiian, or Pacific Islander		

HSP by D/A & MH

■ D/A	41	15.0%
■ MH	102	37.4%
■ Dual Dx	23	8.4%

HSP Applicants Source of Income

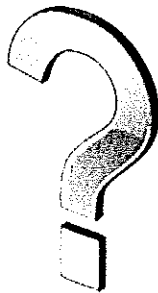
■ Child Support	0	0
■ DPW	94	34.4%
■ SNAP (FS)	176	64.5%
■ Employment	44	16.1%
■ SSD	73	26.7%
■ SSI	99	36.3%
■ Retirement, VA, Other & unknown	14	5.0%

Feedback Process

- 29 complaints filed in 2009
- Services
 - Medical Case Management (20)
 - Miscellaneous complaints including:
 - Attitude of MCM
 - Housing application submission
 - DEFA application submission
 - NCM Transfer
 - DEFA Appeals (5)
 - Dental (4) / 4 in 2010
 - 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



- How many Dental/Oral Health related phone calls did the CSU receive this past year? (What are the top concerns in these Dental related phone calls?)
- Do you collect client data by risk category, if so what is the breakdown by risk and gender?
- Since ACSNJ has closed their doors, has there been any changes/increase in referrals from New Jersey for services? Has there been any concerns on unmet needs?
- What are the client's intake insurance data broken out by age, gender and race?

- Can you show trends by comparing last two year's client needs data with this year's? Did the unit receive any calls from people that say they couldn't afford co-pays or Health Insurance premiums?
- In the town halls we hear about issues with transportation. Has transportation been cited in any complaint calls?