HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes
Thursday, February 15, 2018
2-4 pm

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

Present: Katelyn Baron, Henry Bennett, Keith Carter, Mark Coleman, Tiffany Dominique, Dave Gana, Sharee Heaven, Gerry Keys, Dorothy McBride-Wesley, Nicole Miller, Jeanette Murdock, Terry Smith-Flores, Gail Thomas, Leroy Way, Lorrita Wellington

Excused: Peter Houle, La'Seana Jones, Adam Thompson

Absent: Pamela Gorman, Ann Ricksecker

Guests: Sebastian Branca, Jessica Browne, Kristine Ousley, Victoria Ryan, Chase Staub, Zora Wesley

Staff: Antonio Boone, Nicole Johns, Mari Ross-Russell, Stephen Budhu

Call to Order: T. Dominique called the meeting to order at 2:08pm. Those present then introduced themselves.

Approval of Agenda: T. Dominique presented the agenda for approval**.** N. Johns stated the agenda needed to be updated to include S. Branca's presentation on the new medical case management model. The addition would be under the "Old Business" section. **Motion:** D. Gana moved, G. Keys seconded to approve the updated agenda. **Motion Passed:** All in favor.

Approval of Minutes: T. Dominique presented the minutes for approval. **Motion: G. Keys** moved, L. Way seconded to approve the January 18, 2018 minutes. **Motion Passed:** All in favor.

Report of Chair: T. Dominique stated A. Thompson apologized for his absence, and K. Baron would be helping with meeting facilitation.

Report of Staff:

- **Consumer Survey Report**

N. Johns informed the committee the consumer survey report was completed and it was included in the meeting packet. She explained she would briefly review the report and its recommendations.

N. Johns reviewed the demographics of the survey. Average age of respondents was 53, and 72.2% of respondents were ≥ 50 years old. Only 2.4% were between 18 and 24 years old. Of the respondents roughly $^2/_3$ were male (65.9%), 34.1% female, and 1.3% identified as transgender and 0.3% as gender nonconforming. Of the respondents the majority were African American (62.1%), while 25.3% were White, 6.3% were Hispanic/Latino, and 6.3% were another race [includes biracial/multiracial].

N. Johns explained OHP conducts the consumer survey every 4-5years, and for the first time the survey asked about incarceration history, other comorbidities, and HEP-C diagnosis. In the survey, 19.1% reported having an incarceration history and those who had a previous history of incarceration were more likely to report income less than $1000/month and less likely to have attained higher than a high school education.

N. Johns reviewed other comorbidities reported in the survey. Of the responses, hypertension was the most common at 48.2%, followed by high cholesterol at 30.9%, then lung breathing problems at 19.1%. Other conditions reported: diabetes, nerve issues, liver problems, kidney problems, cardiac problems, and cancer. Mental health disorders were also reported, and the most commonly reported was depression at 51%. Other mental health disorders reported: anxiety, bipolar disorder, schizophrenia/schizoaffective disorder, PTSD, eating disorder, OCD, substance use disorder, and dementia.

N. Johns reviewed Hepatitis C prevalence in the survey. In total, 30% of respondents reported a Hepatitis C diagnosis, of that 30%, 24% reported receiving treatment. Those who reported a HEP-C diagnosis were more likely to report an income lower than $1000/month. Those who reported to have received treatment for their HEP-C diagnosis were more likely to be disabled, retired or unemployed, compared to those who did not have a HEP-C diagnosis, or reported a HEP-C diagnosis that was untreated.

N. Johns reviewed the provider relationship with the survey respondents. 86.9% said that their HIV medical provider had always taken time to explain their lab results, diagnoses, treatment plans and to answer their questions. 71.2% said that they always feel comfortable talking to their HIV medical provider about personal and sensitive issues.

N. Johns discussed the access to HIV services in the survey. The majority (91.3%) did not experience any access problems, while 8.8% reported not getting the services they needed. Those who reported problems accessing services were more likely to be: younger than mean age (54), race other than White, Hispanic, unemployed, uninsured, or have reported incarceration history.

N. Johns explained the survey analysis looked for statistically significant predictors in the those who reported specific sexual behavior and those who did not report those sexual behaviors. Reported sexual behaviors were condom-less anal, oral, vaginal, and trading sex for money or drugs within the last 12 months. The predictors used in analysis are as follows: homeless/marginally housed, having no medical insurance, offered STD or HEP-C testing, offered condoms or safer sex kits, offered partner services, information about disclosure, and information on PrEP. All predictors were statistically significant across the two groups except for homeless/marginally housed and information about disclosure. N. Johns noted those who reported sexual behavior were more likely to report being offered a condom or safe kit (43.8%) and offered STD or HEP-C testing (43.1%) by their providers compared to those who did not report sexual behavior (30.5%, 17.7%). T. Dominique asked if the survey asked about discordant couples or viral load. N. Johns replied the survey did not ask about discordant couples, but the survey did ask about the viral load; the majority stated over 90% being undetectable. T. Dominique suggested the lower rates of provider risk counseling may be due to the higher amounts of PLWH who are undetectable. S. Branca commented, the Recipient was displeased with the amount of people who received risk behavior counseling by providers. He explained providers report to the Recipient that they have about a 98% rate of counsel, but other data sources including the consumer survey suggest otherwise. He stated the Recipient will explore this disconnect with further study.

N. Johns shared the common barriers reported with the committee. Barriers reported were: poverty, transportation, housing costs, or other health conditions. The most commonly reported barrier was transportation.

N. Johns concluded her presentation by discussing the recommendations from the consumer survey report. The recommendations referenced poverty, transportation, homelessness prevention, direct material services risk assessments, age-friendly planning, health literacy, incarceration and prevention in HIV medical care. The recommendations are as follows:

1. HIPC should ease the burdens of poverty for vulnerable PLWH in the EMA by ensuring access to food, housing, emergency financial assistance, and help with health insurance co-pays and deductibles
2. HIPC and AACO should explore ways for Ryan White Medical transportation to provide transportation for PLWH who experience barriers due to Medicaid or Medicare transportation.
3. HIPC should explore how Ryan White funds can best be leveraged to prevent homelessness and provide housing for PLWH. The HIPC should consider options which include Housing First models, emergency financial assistance, and other interventions to prevent homelessness. Such efforts maybe require reallocating resources and adjusting service priorities.
4. The EMA can help PLWH manage and navigate these common barriers to retention and adherence through direct material services like transitional and short-term housing, food banks and home-delivered meals, alternatives to unreliable transportation like on-demand and ride-sharing services, and financial assistance for health insurance costs like premiums, cost-sharing, and deductibles.
5. RW Providers should use targeted risk assessments to predict which patients are at risk for poor retention. PLWH should receive appropriate supports and interventions before they are lost to care rather than interventions after they have missed appointments or are no longer adherent to ART.
6. The EMA's service system has to adjust to meet the needs of our aging population. Examples of possible changes in the RW delivery system include home visits by case managers, enhanced personal contact like follow-up phone calls and check-ins about current needs, support groups for older PLWH, and a focus on holistic care.
7. Educational campaigns for PLWH to assist with health literacy, access, and adherence to treatment are recommended to help PLWH manage complex treatment
8. The HIPC should assess access to and the quality of linkage programs and release planning for PLWH who are incarcerated in the EMA's county jails and New Jersey and Pennsylvania state correctional institutions. Recently incarcerated PLWH are vulnerable to falling out of care and having worsened health outcomes. Pre-enrollment in health insurance and other benefits should be a part of release planning for all incarcerated PLWH regardless of correctional institution. The EMA should work with the correctional systems to get needed services and support to PLWH, including telehealth when necessary.
9. At a minimum, our results speak to a need for training and technical assistance about discussing sexuality, STIs and PrEP for Ryan White clinical providers. Further evaluation about how sexuality and sexual risk is addressed by Ryan White clinical providers is required to fully

After reviewing the recommendations with the committee, N. Johns informed them she is "pen pals" with 2 men who are incarcerated. She stated from the letters that she has received the main concerns from both men are what to do when they are eventually released. T. Dominique asked if there are pre-release plans in the penitentiary system. N. Johns replied there are some planning services that are used. S. Branca stated there are contracted providers who facilitate treatment during their incarceration period. He explained the Recipient funds MCM in the prison system for PLWH. He added there's programs in the system, but he cannot speak on their quality. T. Dominique explained the people seldom know when they are being released, so there's a lack of planning. T. Smith-Flores shared her experiences with dealing with corrections while working with her agency. She explained her agency used to conduct public health visits in prisons.

S. Branca stated he wanted to review the new transportation plan for when SEPTA phased out tokens. He explained the Recipient has been in talks with SEPTA, and the roundtrip single use passes would be available for purchase by agencies who reimburse PLWH for transportation. These passes could not be reloaded and were only valid on certain lines. Once activated these passes would have to be used within 24 hours, and passes are only activated when first used at the SEPTA station. S. Branca said at this time the Recipient felt this was the better route for transportation reimbursement, opposed to day passes.

Action Items: None

Discussion Items:

- **HOPWA Update**

S. Heaven stated she works for OCHD that focuses on the housing and grant development. She explained as HIPC members we have an obligation to talk about housing. Data suggests that housing is key for PLWH linkage to care and retention in care.

S. Heaven stated the HIV epidemic has changed [PLWH are having longer life spans] and the federal HOPWA housing formula has changed to reflect that. In Philadelphia the HOPWA formula accounts for: incidence of HIV, rate of poverty, and fair market rate[1] for rent. The change may hurt larger metropolitan areas with long term PLWH.

S. Heaven explained to the committee it is believed over the next 5 years HOPWA funding will be cut. She noted 1 million dollars in HOPWA funding has been cut already, and the new formula will call for more cuts as well. As a result of the $1 million dollar cut, 147 households will most likely be forced into homelessness. S. Heaven emphasized the 147 was a projection, and the true number of households effected may be greater.

S. Heaven explained the roles of the different housing agencies. Many agencies do fund emergency or transitional housing; however, very few if any fund long-term housing. She explained HOPWA funding in the past used to be leveraged by Project HOME dollars but funding has leveled out. She stated when the HIPC reviews allocations and does their annual priority setting the council should consider putting more funding into housing assistance.

M. Ross-Russell reiterated 147 families at least will be impacted with the million-dollar cut. She asked when the cut will come into effect. S. Heaven replied July 1, 2018. M. Ross-Russell stated this isn’t funding for new placements, but at this point funding to ensure people maintain their housing.

G. Thomas asked if there was new construction for low income housing. S. Heaven relied not at this time. G. Thomas asked about the fair market rent, since rent is continuously increasing. S. Heaven explained the fair market rent was determined on a federal level, so there was little that could be done to adjust the fair market rent. S. Heaven mentioned utilities could be adjusted since it was decided by the Philadelphia Housing Authority (PHA).

M. Ross-Russell informed the committee HUD and HRSA had a joint webinar earlier in 2018, to remind the Ryan White providers that they could also pay for housing, and all parts of Ryan White can pay for housing. Within the webinar the discussion was centered on the best way to leverage housing moving forward. From the webinar, HUD and HRSA recommended temporary housing, which was defined as 2 years. M. Ross-Russell stated the problem is permanent housing has to be available and in many large cities that is not the case.

1. Fair market rents are created by the Housing and Urban Development Office. Sample fair market rent for 19107 is $1100. For more information visit https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2018_code/2018summary.odn

M. Ross-Russell stated the webinar tried to discuss new methods to subsidize housing. She noted there are proposed cuts to HUD on the table.

T. Dominique asked what the role of the Comprehensive Planning Committee (CPC) is in the HOPWA discussion. S. Heaven explained she wanted to inform this committee first since this committee is involved with priority setting. She explained this committee can make a recommendation to the HIPC to review housing. N. Johns said the role of CPC is address funding priorities and review needs. N. Johns stated the committee could make the next steps with the information that was presented.

T. Dominque asked the committee what recommendations if any did they wish to make. T. Smith-Flores mentioned in southern New Jersey they stopped the temporary housing, and relocated into joint housing facilities.

The committee briefly discussed presenting a HOPWA budget to the Finance Committee. D. Gana stated the committee should present a plan with funding estimates. S. Heaven asked what kind of plan was necessary. D. Gana replied a dollar amount or ball park range was needed. M. Ross-Russell reiterated there is a direct correlation between housing and retention in care and suggested the committee should explore additional funding opportunities for housing. She explained Direct Emergency Financial Assistance (DEFA) pays for first and last month's rent. She asked if funding was allocated into DEFA would the money be able to offset some of the housing cuts. She stated this was a possible option if the committee did not want to go the transitional housing route. T. Dominque asked what the transitional/temporary housing route was. M. Ross-Russell replied paying for housing that is 2 years or less.

N. Johns referenced Objective 2.4 of the integrated plan: Increase the percentage of PLWH retained in HIV care who are stably housed. Strategy 2.4.2: Continue and expand access to transitional and long-term housing for PLWH. With this discussion, N. Johns reminded the committee they were doing activities from the integrated plan.

K. Baron stated the committee could make the recommendation to use DEFA money for first and last month's rent. S. Branca stated if you assume fair market rent is 1300-1500 for arithmetic purposes, $225,000 would be needed to help those 147 families.

M. Ross-Russell asked if the first and last month's rents can offset a potentially larger amount, because with a $1 million cut looming, $800,000 is still unaccounted for.

H. Bennett asked what will happen once the program is cut. The money is already spent, specifically first and last month's rent, so what is possibility of getting transitional housing? He added you can't move your housing voucher to another state so there doesn't seem much choice. S. Heaven asked H. Bennett if he doesn't find the DEFA recommendation to be a good idea. H. Bennett replied the recommendation was a good idea, but it doesn't account for new housing opportunities. If you're getting a housing subsidy you do not have access DEFA funding.

S. Heaven stated the HOPWA waitlist had to be changed to meet certain criteria, and with the new list only a few people met that criteria due to funding cuts. She noted just being on one agency's housing wait list would no longer guarantee housing. Agencies now have to give priority to those who fit the federal definition of homeless and rent burdened. H. Bennet asked if a person went on their own and found housing who would work with a subsidy, then would it be feasible [to be housed]. S. Heaven replied yes under those circumstances.

M. Ross-Russell stated the committee needs to come up with a bottom line figure so it can be presented to the Finance Committee. She reminded the committee Ryan White is the payer of last resort, and she asked S. Heaven if there are there other ways to pay for housing. S. Heaven replied this was the last resort.

M. Ross-Russell stated two meetings need to happen, one with the Finance Committee and then one to the HIPC.

Motion: K. Baron moved, T. Dominique seconded to bring the HOPWA conversation to the Finance Committee. **Motion Passed**: All in favor.

- **Brainstorming Activity Review**

Tabled due to time constraints

Old Business:

S. Branca reviewed the new medical case management (MCM) model with the committee. He reiterated the model has not been finalized, but it has been in the works since 2016. He explained the rationale for a new MCM model was:

- Analysis showed sporadic rather than frequent utilization by clients over the past five years
- Performance outcomes demonstrated that large numbers of clients are not actionable
- A more flexible model needed to respond to a large and diverse service delivery system

S. Branca added the existing MCM model does not differentiate between high and low acuity clients. To gather data an MCM survey was conducted in summer 2016, and the survey had 136 respondents; he mentioned 136 was practically all the MCM providers the Recipient has a relationship with. He explained survey questions pertained to documentation, health literacy, caseload, treatment adherence, medical care linkage, and graduated disengagement. The results helped identify areas that needed improvement in MCM model that were not measurable by performance such as: comprehensive assessment, service care plans, and disengagement protocol.

S. Branca stated a committee was formed to look at the disparity between medical and CBO caseloads and their feedback was used to create the new MCM model. Currently there is a one size fits all model that doesn't work in every setting. Also, the Recipient did focus groups on MCM about what should be changed. The main takeaway from the focus groups were the MCM model was adequate, it met the needs for what was happening, the model had a good backbone, flexibility just needed to be added to the model.

S. Branca stated from the information that was gathered, the Recipient proposed a binary MCM model that is acuity based. The model will have 2 parts: comprehensive MCM and standard MCM, and the client will be able to choose what type of case management they prefer. The MCM provider will of course explain the pros and cons of each type of case management and explain how it will meet client need.

S. Branca stated to be enrolled in comprehensive MCM the client must have some number of the following:

- Newly diagnosed
- Not virally suppressed
- Not treatment adherent
- High acuity
- Intimate Partner Violence
- Recent Incarceration
- Unstable Housing
- Adolescent or pediatric
- Untreated Hepatitis C
- Other Comorbidities

To be enrolled in the standard MCM the client must have the following:

- New client without enough information to determine model
- Not ready to engage Comprehensive MCM
- Not newly diagnosed
- Virally suppressed
- Adherent to treatment
- Low acuity

S. Branca stated the comprehensive MCM criteria seems like it would include a lot of PLWH, but only 15% of PLWH in the Ryan White continuum in the Philadelphia EMA are not virally suppressed, 19% are incarcerated, and finally only a few PLWH meet the CareWare definition for unstable housing.

S. Branca informed the committee new clients will enroll for MCM from the Client Services Unit (CSU)

The CSU will conduct a rapid assessment of first time clients; those clients who are returning will have their enrollment expedited. S. Branca reviewed the minimum requirements for both types of MCM in the new model. For comprehensive MCM:

- Comprehensive Assessment and Plan (CAP)
- Care coordination with medical provider required
- Face-to-Face contact every 90 days
- Non-Face-to-Face contact every 30 days
- Reassessment after 180 days

For standard MCM:

- Rapid Assessment and plan (RAP)
- Care coordination with medical provider recommended
- Contact every 180 days
- Frequency of contact dictated by the client
- Reassessment after 180 days.

S. Branca reviewed the discharge protocol for the new MCM model. He stated case managers will now have to complete a discharge plan to help the client to get to the next step, or if a client has fallen out of care. He explained discharge protocol would have to be used in all of the following situations:

- If minimum frequency for Standard or Comprehensive MCM not met, initiate outreach plan
- Document Discharge Plan in CAREWare using Service Care Plan Creation/Update field
- Close client in CAREWare unless client is receiving other RW services at agency
- If receiving other Ryan White services, indicate Closed on Comprehensive or Supportive dropdown

S. Branca finished his presentation by reviewing the program reporting in the new MCM model. He explained the program reporting protocol calls for:

- Units of service will remain the same
- Agencies will have flexibility to determine how caseloads are distributed between MCMs
- Standard versus Comprehensive MCMs
- MCMs maintaining mixed caseloads
- Program goals will not distinguish between Standard and Comprehensive MCM
- AACO will monitor fidelity to model using agency Viral Load suppression rates, diagnosis dates, housing status and insurance

H. Bennett asked if PLWH still have to go through the client services unit even when they have been virally suppressed for a while. He explained he knows PLWH who do not have a case manager. Those PLWH may have been Ryan White eligible, but he stated they were unaware of Ryan White and his providers do not mention Ryan White at all. S. Branca noted the individual may not have been Ryan White eligible. G. Keys asked if their providers were private offices. H. Bennett replied he was unsure, and it may not have been a Ryan White clinic.

K. Carter stated the Ryan White Card should be the same thing as the SDBP card. He explained only one card should be necessary, and it would be easier for PLWH.

K. Carter asked when the new MCM model goes in effect, and S. Branca replied summer 2018.

New Business: None

Announcements: None

Adjournment: Meeting adjourned by consensus at 3:58 pm.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- Consumer Survey Report
- Ryan White 16-02 Housing Services
- OHP Calendar